

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5729 CERTIFICATE OF DEATH

05724

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. Co.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Dr. H. General Hosp.</i>				d. STREET ADDRESS <i>16 Carver St.</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Henrietta Adams</i>				4. DATE OF DEATH Month Day Year <i>6 11 1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-15-1886</i>		9. AGE (In years last birthday) <i>70</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>A. A. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>J.P.</i>				14. MOTHER'S MAIDEN NAME <i>Annie Hebron</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <i>Walter Adams - 25 Bunch St.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Borderline Vascular Disease</i> DUE TO <i>Nephrosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hemip</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>6/6</i> , 19 <i>56</i> , to <i>6/11</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>6/11</i> , 19 <i>56</i> , and that death occurred at <i>10:15 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Theodore H. Johnson M.D.</i>				ADDRESS (Street, city or town, state) <i>37 Chest St., Annapolis, Md</i>			
DATE SIGNED <i>6/12/56</i>							
PHYSICIAN'S NAME (Type) <i>DR. THEODORE H. JOHNSON</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>6-13-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II</i>				ADDRESS <i>Annapolis, Md</i>		24a. REC'D BY REGISTRAR <i>Dr. Wm. J. Punch</i>	
DATE <i>6-14-56</i>				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

BUREAU V. 2

JUN 14 1956

RECEIVED

DR. THOMAS H. JOHNSON

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05725

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Odenton</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		STREET ADDRESS		(If rural give location)	
TOWN <u>Millersville</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Maggie</u> <u>Arrington</u>				<u>6</u> <u>18</u> <u>1956</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Widowed</u>		<u>Nov. 15, 1876</u>	
9. AGE last birthday		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>79</u> yrs.		<u>Housewife</u>		<u>Own Home</u>		<u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
<u>USA</u>		<u>Oliver Bayne</u>		<u>Harriett Boblitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Family Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>204.2</u> IMMEDIATE CAUSE (A) <u>Acute Monocytic Leukemia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3+ weeks</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Generalized arteriosclerosis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		White <input type="checkbox"/> Not white <input type="checkbox"/>					
		M. at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>6/1/56</u>, 19<u>56</u>, to <u>6/18</u>, 19<u>56</u>, that I last saw the deceased alive on <u>6/13</u>, 19<u>56</u>, and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Frank M. Shipley</u>		<u>M.D. 63 College Ave Annapolis Md 21403</u>		<u>6/18/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 20, 1956</u>		<u>Prospect Hill Cemetery</u>		<u>Towson, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE 6-21-56</u>		<u>Katherine M. Joyce</u>		<u>John Eugene Bone</u>		<u>Towson, Maryland</u>	

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Date of death

7. Cause of death

8. Immediate cause of death

9. Underlying cause of death

10. Manner of death

11. Physician's signature

12. Date of death

13. Place of death

14. Signature of informant

15. Signature of registrar

16. Signature of medical examiner

17. Signature of coroner

BUREAU V. 2

JUN 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05726
Reg. Dist. No. 28

5758

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>3 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville,</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>VIRGIE</u> Middle <u>A</u> Last <u>ASBURY</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>19,</u> Year <u>19 56</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 16, 1921</u>		9. AGE (In years last birthday) <u>35 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>				11. BIRTHPLACE (State or foreign country) <u>Yeager, West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Joseph Cooper</u>						14. MOTHER'S MAIDEN NAME <u>Maggie (Unknown)</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Arthur Asbury- husband- same as # 2</u>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Disease</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural causes</u>											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>6-19-56</u> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>June 19, 1956</u>							
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>						ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>6/20/1956</u>		24b. REGISTRAR'S SIGNATURE <u>Katharine M. Joyce</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be signed by the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MINNESOTA STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUN 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5759

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARLEY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARLEY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7214 MARLEY NECK RD</u>				d. STREET ADDRESS <u>7214 MARLEY NECK RD</u>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>BOZER</u> Last <u>BOZER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 1896</u>	
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>FRANK BOZER 7214 MARLEY NECK RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac decompensation</u> DUE TO (c) <u>generalized arteriosclerosis</u> <u>not known</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized hypertrophic arthritis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January 4, 1955</u> , to <u>June 19, 1956</u> , that I last saw the deceased alive on <u>June 19, 1956</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u> DATE SIGNED <u>June 19, 1956</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>				ADDRESS <u>Pasadena, Md.</u> DATE SIGNED <u>June 19, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>RITCHIE NEWY ADCO, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Conner</u> ADDRESS <u>4001 Ritchie Hwy</u>				24a. REC'D BY REGISTRAR DATE <u>6-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Louis J. DeAlba</u>	

CERTIFICATE OF DEATH

BUREAU V. 2

JUN 22 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose a certificate from the funeral director, stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montivideo Rd.</u>				d. STREET ADDRESS <u>Same</u>			
3. NAME OF DECEASED (Type or print) <u>William Buffen</u> First Middle Last				4. DATE OF DEATH Month <u>June</u> Day <u>24th</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/19/05</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred Buffen</u>				14. MOTHER'S MAIDEN NAME <u>Amelia ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2P7-09-1322</u>		17. INFORMANT Address <u>807 Coolidge Ave.</u> <u>Mrs. Amelia Buffen (Mother)</u> <u>Baltimore, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Wm. V. Lovitt, Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		<u>6/25/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-28-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Dorsey, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard, 4107 Wilkens Ave.</u>				24a. REC'D BY REGISTRAR <u>June 28 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Hadley</u>	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW/STP

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

231

STATE OF NEW YORK

BUREAU V. 2

JUN 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5761

CERTIFICATE OF DEATH

05729

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Calvert</u> First <u>W.</u> Middle <u>Burley</u> Last		4. DATE OF DEATH <u>June</u> Month <u>98</u> Day <u>1956</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12 1907</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>5</u> Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer P. & B. Road Education</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bristol Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Burley</u>		14. MOTHER'S MAIDEN NAME <u>Francis Baden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-16-194</u>	
17. INFORMANT <u>Dorothy Burley</u> Address <u>Bristol Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>023X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lucetic C.V. Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 min</u> <u>2 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>54</u> , to <u>28 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>25 June</u> , 19 <u>56</u> , and that death occurred at <u>5:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. B. Casser</u> M.D.		ADDRESS (Street, city or town, state) <u>Upper Marlboro Ind.</u> DATE SIGNED <u>6-24-56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/24/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moses</u>		22d. LOCATION (City, town, or county) (State) <u>Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson</u> ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR <u>July 2, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Ida Belle Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) a. STATE <u>Maryland</u> b. COUNTY <u>D.C. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prinneapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prinneapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>433 East Street</u>		d. STREET ADDRESS <u>433 East Street</u>	
3. NAME OF DECEASED (Type or print) <u>Daisy (Ray) Butler</u>		4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-1885</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>D.C. Co. Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Ray</u>	
14. MOTHER'S MAIDEN NAME <u>Maragret Queen</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Soldier, Jr. - 433 East St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 42: DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Cardiovascular Dis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> 19 <u>55</u> to <u>June</u> 19 <u>56</u> , that I last saw the deceased alive on <u>June 10</u> 19 <u>56</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Faye W. Allen</u>		ADDRESS (Street, city or town, state) <u>62 Cathedral St. - Annapolis</u>	
PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>		DATE SIGNED <u>6-12</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u> </u>	<u>6-14-56</u>	<u>Beverly Hill</u>	<u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md</u>		24a. REC'D BY REGISTRAR DATE <u>6 14 56</u>	24b. REGISTRAR'S SIGNATURE <u>Mr. Jim J. Fene</u>



1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05731

5762

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Kentucky</u>		COUNTY <u>Jefferson</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort G. G. Meade, Md.</u>		LENGTH OF STAY (in this place) <u>2 Months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Louisville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>734 S. Shelton Street</u>			
3. NAME OF DECEASED (Type or Print) <u>PAUL DAVID CATHEY</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>30</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>29 June 1956</u>	9. AGE last birthday yrs. <u>9</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert E. Cathey</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Deane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Father, Apt T-1235-C</u> <u>Fort Meade, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Anoxia</u>				<u>Chronic</u>		<u>9 Hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atelectasis</u>				<u>Chronic</u>		<u>6 Hours</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST DUE TO (C) <u>Immaturity</u>				<u>Immaturity</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>29 June</u>, 19<u>56</u>, to <u>30 June</u>, 19<u>56</u>, that I last saw the deceased alive on <u>30 June</u>, 19<u>56</u>, and that death occurred at <u>0830</u> M., from the causes and on the date stated above.							
SIGNATURE <u>RICHARD M. McQUANE</u>		1ST LT, MSC		ADDRESS (Street, city, town, state) <u>U.S. Ft. Meade, Md.</u>		DATE SIGNED <u>30 June 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-3-56</u>		NAME OF CEMETERY OR CREMATORY <u>Nat'l. National</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. I. Saylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M. COCK, INC., BALTO., MD</u>		ADDRESS	
DATE <u>30 June 56</u>		W. I. SAYLOR, 1ST LT, MSC					

12/12/17

12/12/17

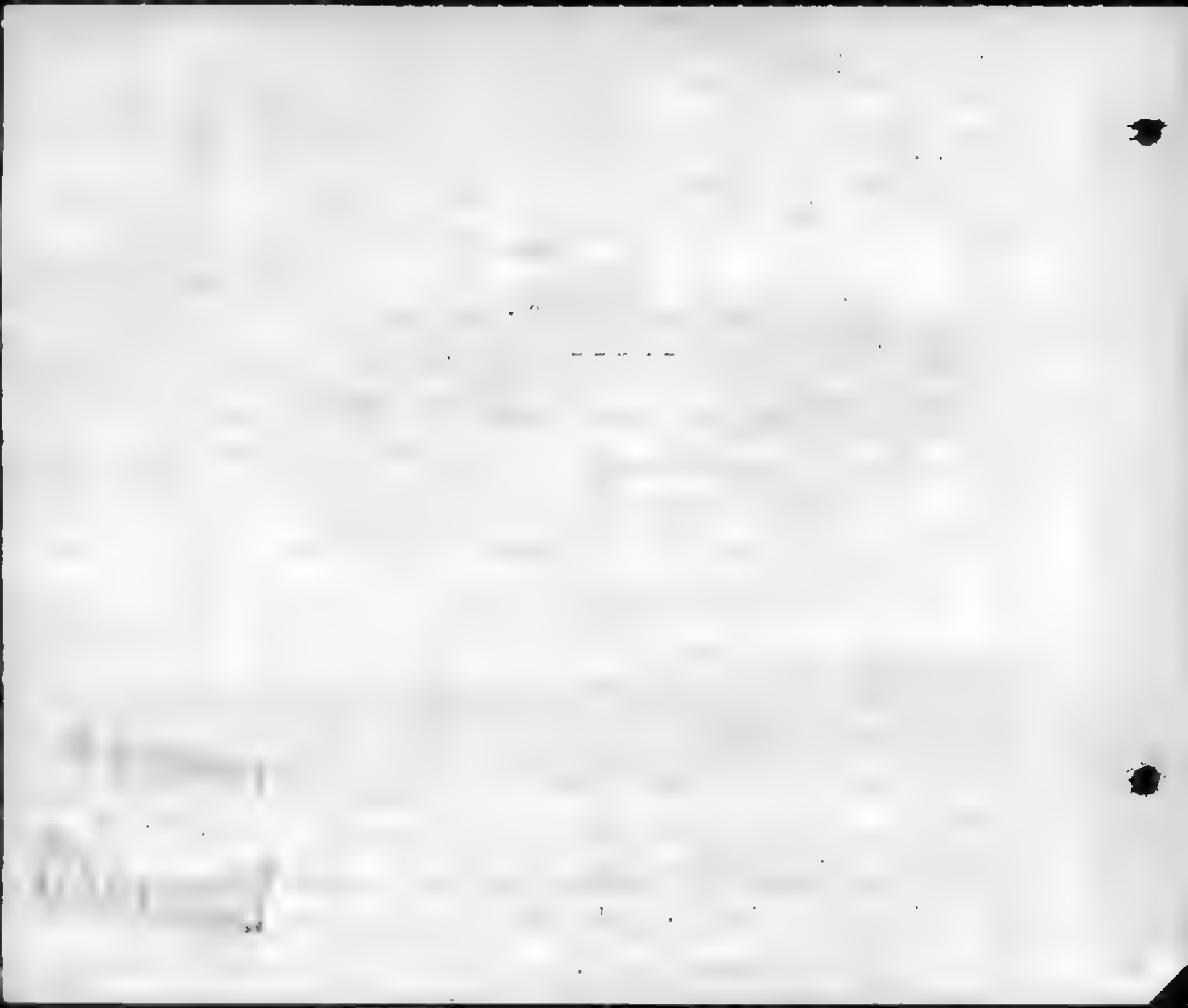
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5763 CERTIFICATE OF DEATH

05732

Reg. Dist. No. 20

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Moreland Nursing Home				d. STREET ADDRESS Moreland Nursing Home			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EMMA M CHESTNUT				4. DATE OF DEATH Month Day Year JUNE 20 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 30 1869	
9. AGE (In years last birthday) 86 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Asaph Sherwood				14. MOTHER'S MAIDEN NAME Delphine Bussee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. nOne		17. INFORMANT Address Personal records of Deceased			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO Diabetic mellitus (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from March 2, 1954 to June 20, 1956 , that I last saw the deceased alive on June 3, 1956 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Emily H. Wilson				ADDRESS (Street, city or town, state) St. Louis, Mo.			
DATE SIGNED 6-21-56							
PHYSICIAN'S NAME (Type) Emily Wilson M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 25, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 6/27/56	
				24b. REGISTRAR'S SIGNATURE Elmer H. Williams			



Page 1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5731
CERTIFICATE OF DEATH

05733

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 Southgate Ave.</u>		d. STREET ADDRESS <u>15 Southgate Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>ROSALYN SYLVESTER CHEW</u>		4. DATE OF DEATH <u>June 4 19 56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1868</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>19</u> Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Sylvester</u>		14. MOTHER'S MAIDEN NAME <u>Marinda Ellis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Capt. John L. Chew U.S.N. #2</u>	
17. INFORMANT <u>Capt. John L. Chew U.S.N. #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Azotemia</u> DUE TO <u>Hypertensive Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis generalized</u> DUE TO (c) <u>5 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1950</u> to <u>June 4, 1956</u> , that I last saw the deceased alive on <u>June 2, 1956</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u> DATE SIGNED <u>6/5/56</u>	
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u> <u>ANNAPOLIS, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/6/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Annes</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor and Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>June 5, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>J. J. Danach</u>	

BRUNNEN & S.

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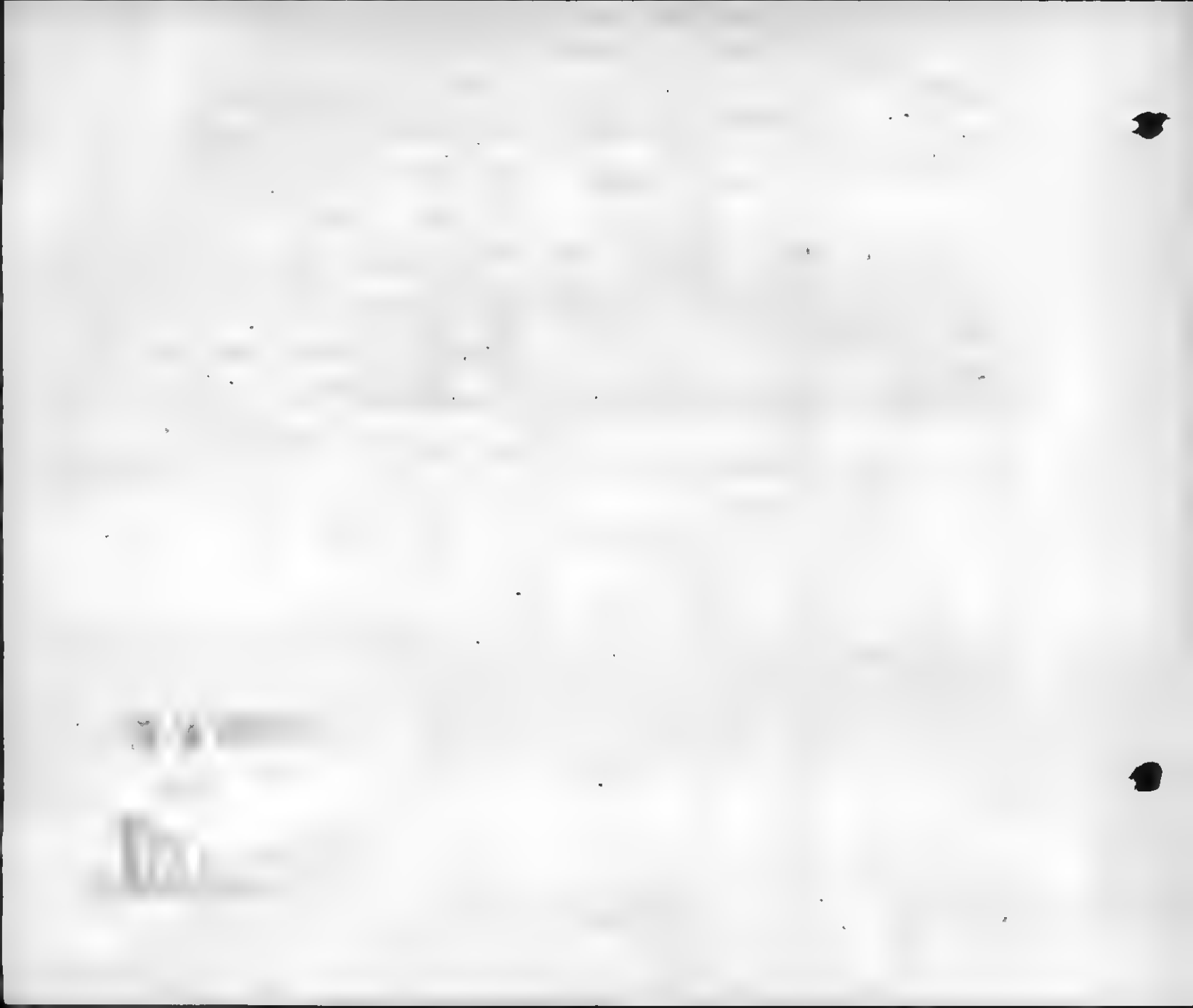
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5764 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05734

Reg. Dist. No. **24**

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Q. D.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>R.F.D. #2 Box 31</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>CLINTON</u> Last <u>COLLIFLOWER</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10 1954</u>		9. AGE (In years last birthday) <u>2</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE C COLLIFLOWER</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET L. COCKRELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>GEORGE C. COLLIFLOWER</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>g.a. drowning</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u> </u></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.) <u>Fell off Press</u>					
20c. TIME OF INJURY Month, Day, Year <u>PM 6/16/56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Beach</u>		20f. (City or town) (County) (State) <u>A.R. MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. Lohardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. Lohardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEM</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>6-18-1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

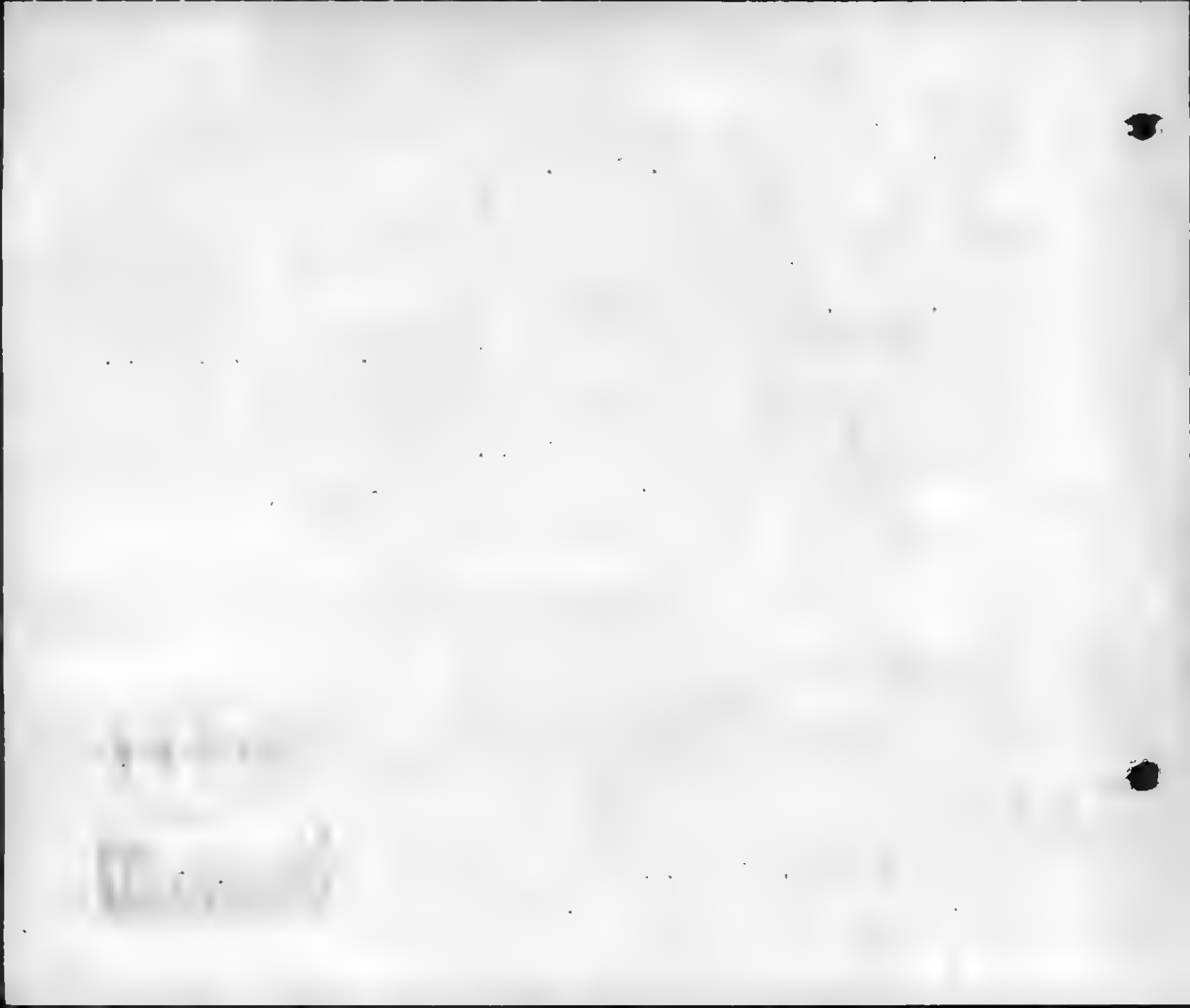
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05735

Reg. Dist. No. 28

5765

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN 1b <u>3m. 21 days.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Elvaton (Old Joppa Rd.)</u>			d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bernadette</u> Middle <u>Day</u> Last <u>Day</u>			4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>56</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/23/56</u>		9. AGE (in years last birthday) yrs. <u>3</u> Months <u>21</u> Days <u>21</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Provident Hosp. Baltimore, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard Day</u>			14. MOTHER'S MAIDEN NAME <u>Hilda Evangeline Scott</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hilda E. Day (Mother)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to aspiration of vomitus.</u> DUE TO (b) <u>121.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/15/56</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Glan Burnie, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried June 17/56</u>		22b. DATE THEREOF <u>June 17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gones Station Hill</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Annal A. Johnson</u>		ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR <u>6-18-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Katharine M. Joyce</u>	



5732

CERTIFICATE OF DEATH

Reg. Dist. No.

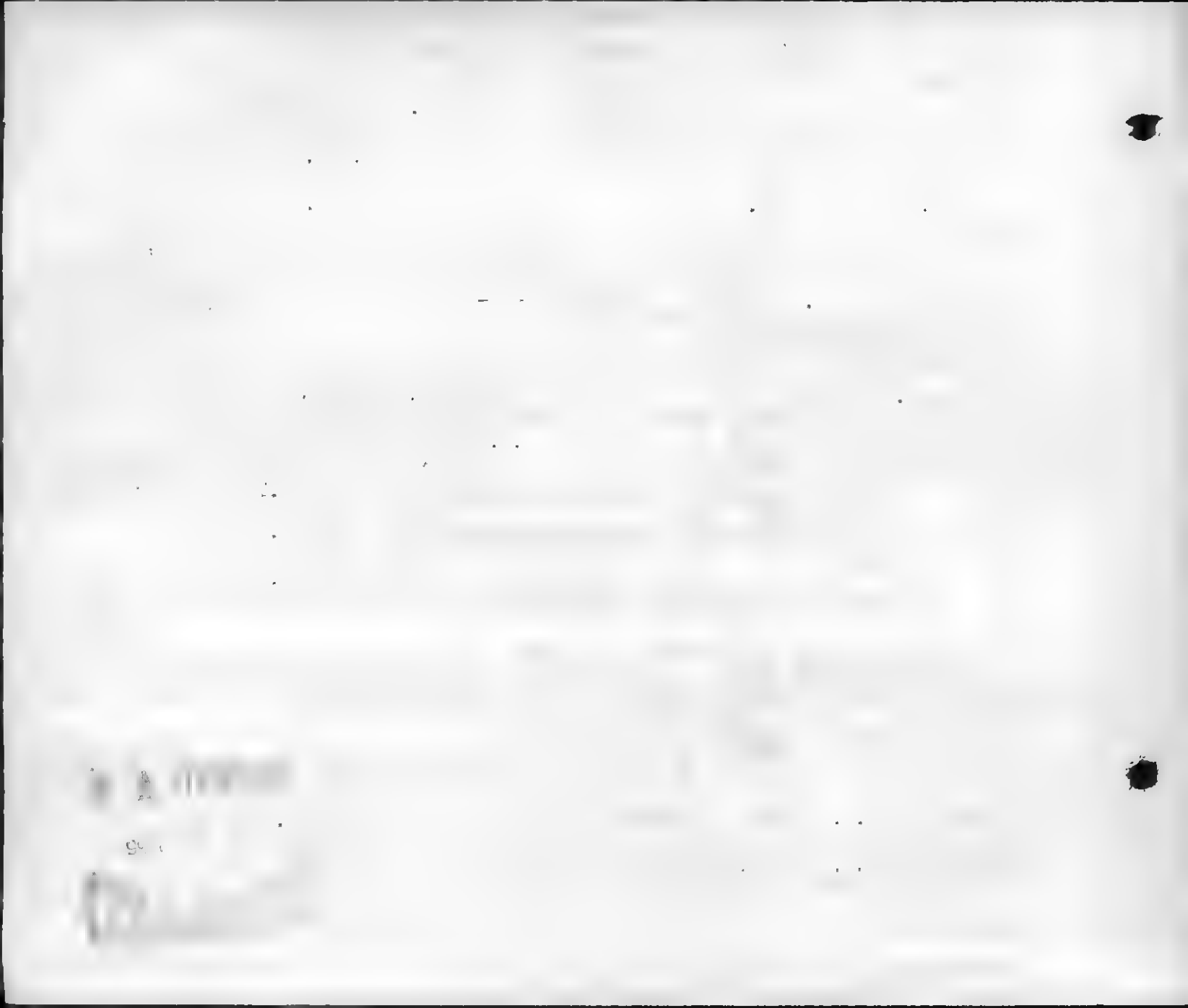
21

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, Annapolis, Md.		d. STREET ADDRESS Gambrills, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last Clifford Vernon DEFOREST		4. DATE OF DEATH Month Day Year 6 24 1956	
5. SEX M	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-87
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 4 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN		10b. KIND OF BUSINESS OR INDUSTRY RET	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elem E. DEFOREST		14. MOTHER'S MAIDEN NAME HEAGIE, Gertrude	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT U.S. Naval Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY X IMMEDIATE CAUSE (a) Failure Heart Congestive 434.1		INTERVAL BETWEEN ONSET AND DEATH 02 Years	
DUE TO 120.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Subacute Bacterial Endocarditis 430.0	
DUE TO (c) Arteriosclerotic Heart Disease 420.0		10 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-19-56 , 19____, to 6-24-56 , 19____, that I last saw the deceased alive on 6-24 , 19____, and that death occurred at 0735 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE S.S. WRIGHT, LT MC USNR		ADDRESS (Street, city or town, state) DATE SIGNED USNH, Annapolis, Md. 6-24-56	
PHYSICIAN'S NAME (Type) S.S. WRIGHT, LT MC USNR			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-27-56	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson, Jr.		ADDRESS 1300-N 5th NW Washington, D.C.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE John J. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5766
CERTIFICATE OF DEATH

05737

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 11 mos 26 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle Delaney Last Delaney		4. DATE OF DEATH Month 6 Day 23 Year 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 13 85
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 9 Days 23 Hours 00 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jack Smith		14. MOTHER'S MAIDEN NAME Mamandor Langley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia 493x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Edema DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus Ulcers, Malnutrition, Pneumonia, Pyelitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 28 55 to 6 23 56 , that I last saw the deceased alive on 6 22 1956 , and that death occurred at 4:05 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville Md. 6 23 56			
ACTUAL SIGNATURE Ludwig Benedict		PHYSICIAN'S NAME (Type) Ludwig Benedict	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF June 27, 1956	
22c. NAME OF CEMETERY OR CREMATORY Amelia Va		22d. LOCATION (City, town, or county) (State) Amelia Va	
23. FUNERAL DIRECTOR'S SIGNATURE Miss Kate R. Williams		ADDRESS 322 N. Schenck St.	
24a. REC'D BY REGISTRAR 28 10 56		24b. REGISTRAR'S SIGNATURE L. M. Joyce	

24-11-1975

10

10/11/75

20

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

1912

1912

1912

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5768

CERTIFICATE OF DEATH

05739

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Anne-Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magothy Beach</u>		c. LENGTH OF STAY IN 1b <u>7 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magothy Beach</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Magothy Beach Rd + Riverside</u>				d. STREET ADDRESS <u>Magothy Beach Rd + Riverside</u>			
3. NAME OF DECEASED (Type or print) <u>Clarence S. Emmons Sr.</u>				4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1956</u>			
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/28/1882</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass Blower</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Swindell & Co.</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO <u>-</u>		17. INFORMANT <u>Mr Nelson Emmons</u>		Address <u>4088 Clement St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> (c) <u>Arteriosclerotic Cardio-Vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 years</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/5</u> , 19 <u>56</u> , to <u>6/27</u> , 19 <u>56</u> that I last saw the deceased alive on <u>6/24</u> , 19 <u>56</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Riviera Beach, Md.</u>		DATE SIGNED <u>6/27/56</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>				<u>RIVIERA BEACH, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>3801 Frederick - Ave</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan + Son</u>				ADDRESS <u>24 Hollins St.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. Delby</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 1

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to a burial-transit permit. File pages 3 and 4 with the registrar prior to a burial-transit permit. File page 5 with the registrar prior to a burial-transit permit.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5769

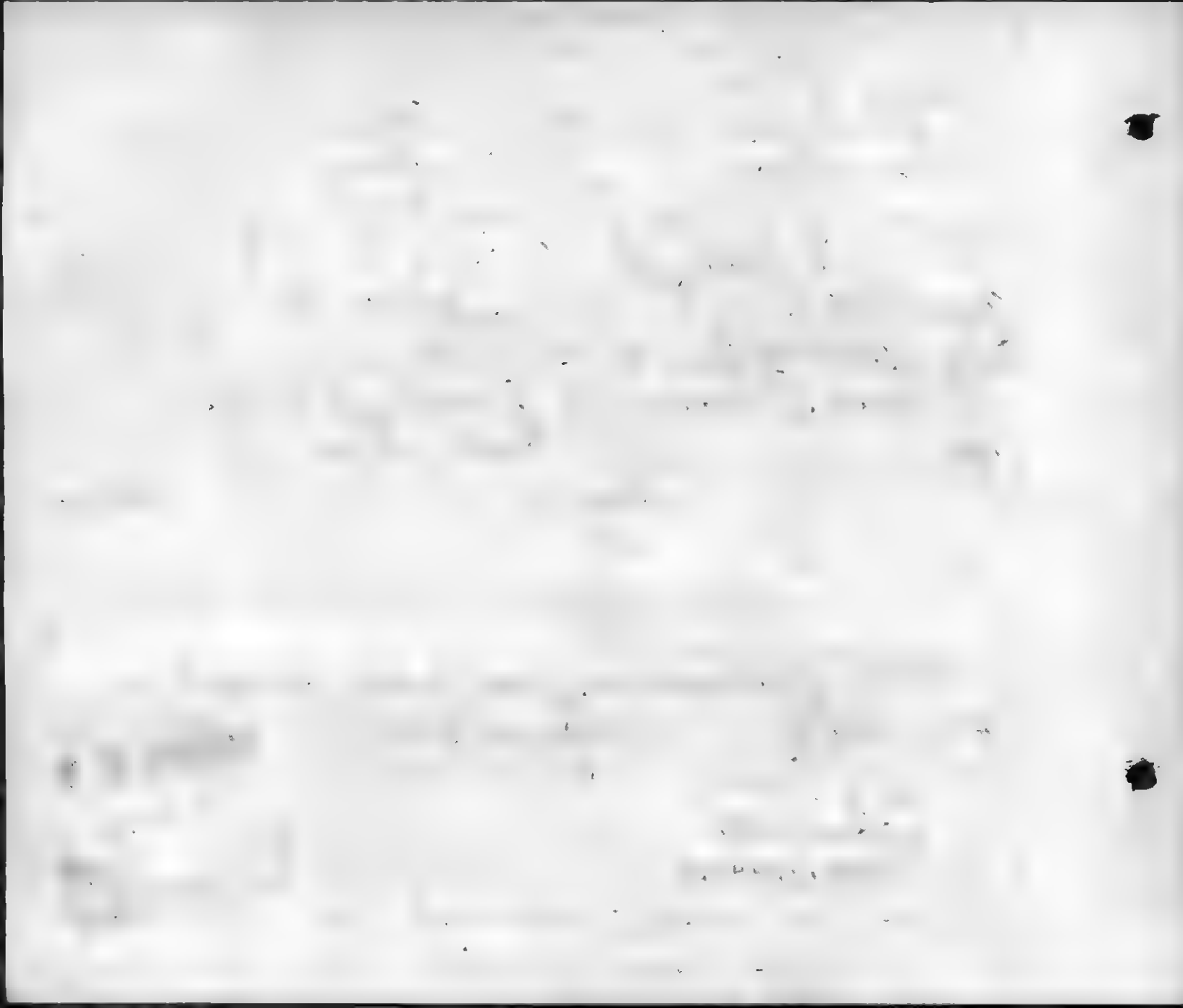
Reg. Dist. No.

05740 7/1

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn River</u>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>2021 Fleet</u>							
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>E.</u> Last <u>FISHER</u>				4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29th 1928</u>	
9. AGE (In years last birthday) <u>28</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver of small truck Owens Boat Co</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penn</u>			
11. BIRTHPLACE (State or foreign country) <u>Penn</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Earnest E. Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy J. Witters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>(if yes, give war or dates of service)</u>		17. INFORMANT <u>Myrtle L. Fisher</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Thrown out of boat while making turn</u>			
20c. TIME OF INJURY Month <u>6</u> Day <u>24</u> Year <u>1966</u> Hour <u>AM</u> a. m. <u>6:45</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Severn River</u>				20f. (City or town) (County) (State) <u>PACO MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>ELNER LINHARDT</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>ELNER LINHARDT</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>6-26-56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Church</u>				22d. LOCATION (City, town, or county) (State) <u>Cassville PA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook/Inc. 1217 St Paul St</u>				24a. REC'D BY REGISTRAR <u>Chas. H. Shipps</u>			
				24b. REGISTRAR'S SIGNATURE <u>Chas. H. Shipps</u>			

DATE SIGNED

6/24/76



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5733 CERTIFICATE OF DEATH

05741

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNAPOLIS</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Anne's Hospital</u>				d. STREET ADDRESS <u>215 Chestnut Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>Harriester</u> Middle <u>Tossie</u> Last <u>Harriester</u>				4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-17-1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u>		11. IF UNDER 24 HRS Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dom. Co. Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Harry Bowie</u>				14. MOTHER'S MAIDEN NAME <u>Tossie Ennis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>1-21-56</u>			
17. INFORMANT <u>Elizabeth Harriester</u>				Address <u>215 Chestnut Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerotic Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular disease</u> (c) <u>Cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>June 17, 1956</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 17, 1956</u> to <u>June 17, 1956</u> , that I last saw the deceased alive on <u>June 17, 1956</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robt. Richardson</u> M.D.				ADDRESS (Street, city or town, state) <u>110 - Clay St Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robt. Richardson</u>				DATE SIGNED <u>6/18/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>				ADDRESS <u>Annapolis, Md.</u>			
24a. REC'D BY REGISTRAR <u>Dr. J. J. Smith</u>				24b. REGISTRAR'S SIGNATURE <u>Dr. J. J. Smith</u>			
DATE <u>6-21-56</u>							

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X

Handwritten text, possibly a signature or name, written in a cursive script.

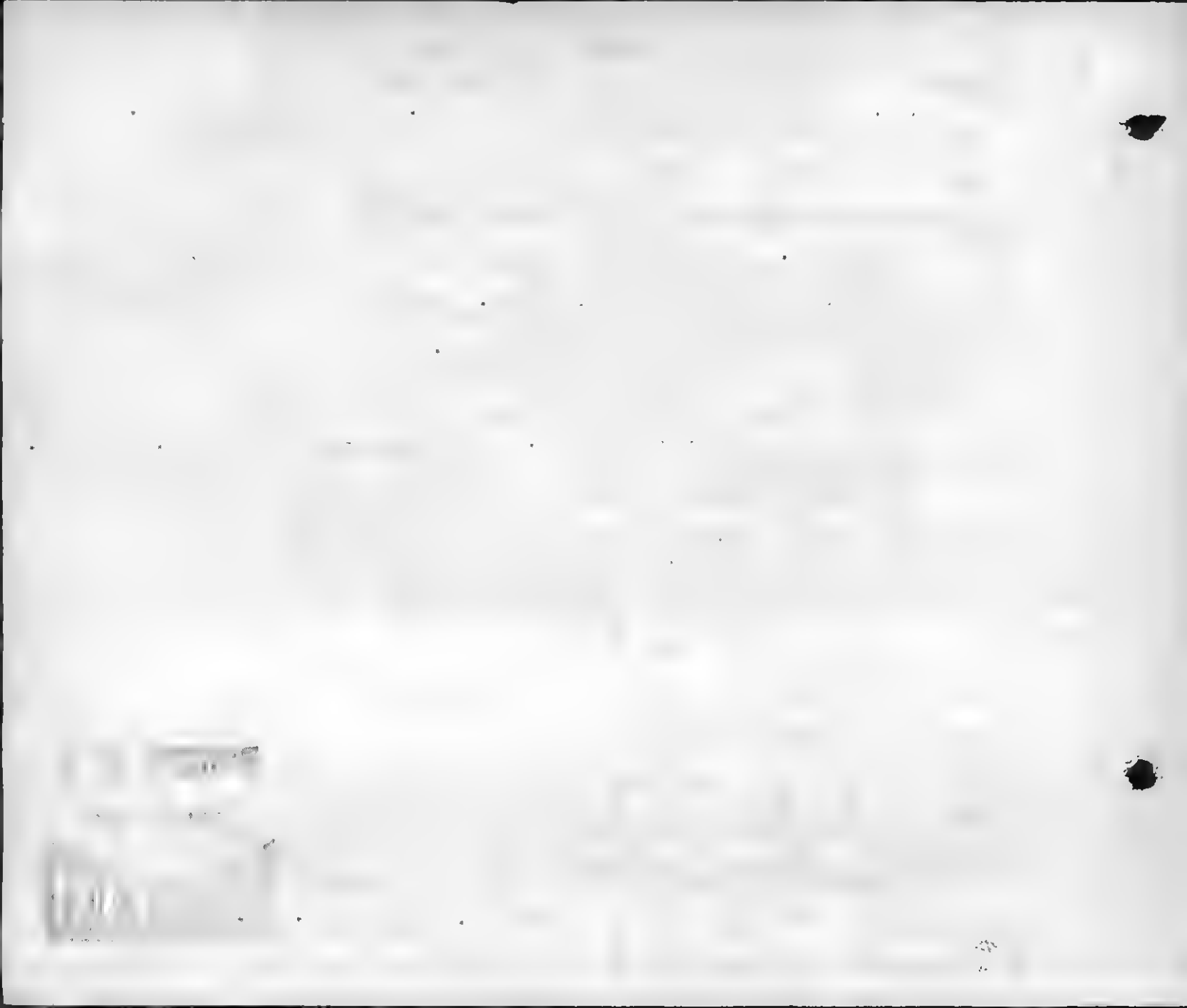
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the FUNERAL DIRECTOR. This certificate has been signed by the attending physician and completely filled in by the burial director.

5770

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived) a. STATE Md.		b. COUNTY BALTO. A. A. Co.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Patapsco Club, RFD # 6 Stella Maris Hospice				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First T.		Middle JEROME		Last GOLLERY		4. DATE OF DEATH Month June Day 5 Year 1956	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 30, 1890		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Funeral		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY			
13. FATHER'S NAME Thomas Gollery				14. MOTHER'S MAIDEN NAME Catherine McDermott					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-03-4901		17. INFORMANT Address Mrs. Garrett Hauser-4800 Lackawanna, College Pk., Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY INSUFFICIENCY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH ACUTE 14 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) BALTO.		(County) (State)	
21. I certify that I attended the deceased from 11/18 , 1952, to 6/5 , 1956, that I last saw the deceased alive on 5/10 , 1956, and that death occurred at 11:30 A.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE C. Edward Leach				ADDRESS (Street, city or town, state) 14 E. Eager St				DATE SIGNED	
PHYSICIAN'S NAME (Type) C. EDWARD LEACH									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/56		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem		22d. LOCATION (City, town, or county) Balto., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto				24a. REC'D BY REGISTRAR 17 May		24b. REGISTRAR'S SIGNATURE L. J. DeAlly		DATE JUN 8 1956	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5771

CERTIFICATE OF DEATH

05743

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena TFD (Jacobsville)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena TFD (Jacobsville)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rock Creek Road</u>				d. STREET ADDRESS <u>Rock Creek Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>M.</u> Last <u>Gray</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 31, 1870</u>	
9. AGE (In years last birthday) yrs. <u>86</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. Months <u>4</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Melville S. Dunlap</u>				14. MOTHER'S MAIDEN NAME <u>Laura V. Jacobs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>None</u>		17. INFORMANT <u>Miss Florence Dunlap</u>		Address <u>Pasadena, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>444x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>auricular fibrillation</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>1 week</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Pasadena, Md.</u>				20g. (County) <u>Pasadena</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>July 17, 1951</u> , to <u>June 1, 1956</u> , that I last saw the deceased alive on <u>June 1, 1956</u> , and that death occurred at <u>4:50 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.M. McLaughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u>			
PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin, M.D.</u>				DATE SIGNED <u>June 1, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 4, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.T. Feigelson</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. Dealla</u>			

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5734

CERTIFICATE OF DEATH

05744
Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>13 Water Street</u>				d. STREET ADDRESS <u>13 Water Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Green</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-11-1905</u>	9. AGE (In years lost birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Frank Green Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Martha Cross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>012-12-1004</u>		17. INFORMANT <u>Russell Scott 711 1/2 St. S.E. Wash. D.C.</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>3 days</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2130 1st St. S.E. Wash. D.C.</u>		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 6, 1956</u> to <u>June 6, 1956</u> , that I last saw the deceased alive on <u>June 6, 1956</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.L. Richardson</u>				ADDRESS (Street, city or town, state) <u>110 CLAY ST ANNAPOLIS</u>			
PHYSICIAN'S NAME (Type) <u>R.L. Richardson M.D.</u>				DATE SIGNED <u>June 6, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Lee Thompson, Md.</u>				24a. REC'D BY REGISTRAR <u>Dr. Wm. J. French</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. J. French</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5772 CERTIFICATE OF DEATH

06819

Reg. Dist. No. 28

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 5yrs. 2mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. STREET ADDRESS 437 Pennsylvania Avenue	
3. NAME OF DECEASED (Type or print) First Birdella Middle Hill Last Hill		4. DATE OF DEATH Month 6 Day 26 Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/05
9. AGE (In years (last birthday)) 51 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia with Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral vascular Thrombosis and Coma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/19 , 19 56 , to 6/26 , 19 56 , that I last saw the deceased alive on 6/26 , 19 56 , and that death occurred at 3:35 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/27/56			
ACTUAL SIGNATURE R. Weber M. D. M.D.		PHYSICIAN'S NAME (Type) Konstantin Weber	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/56	
22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital		22d. LOCATION (City, town, or county) (State) Crownsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph H. Hays		24a. REC'D BY REGISTRAR DATE 7-3-56	
ADDRESS Crownsville, Md.		24b. REGISTRAR'S SIGNATURE H M Jace	

8. 10. 1946
10. 10. 1946

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 4, 9 Filed 1996-22-24 et

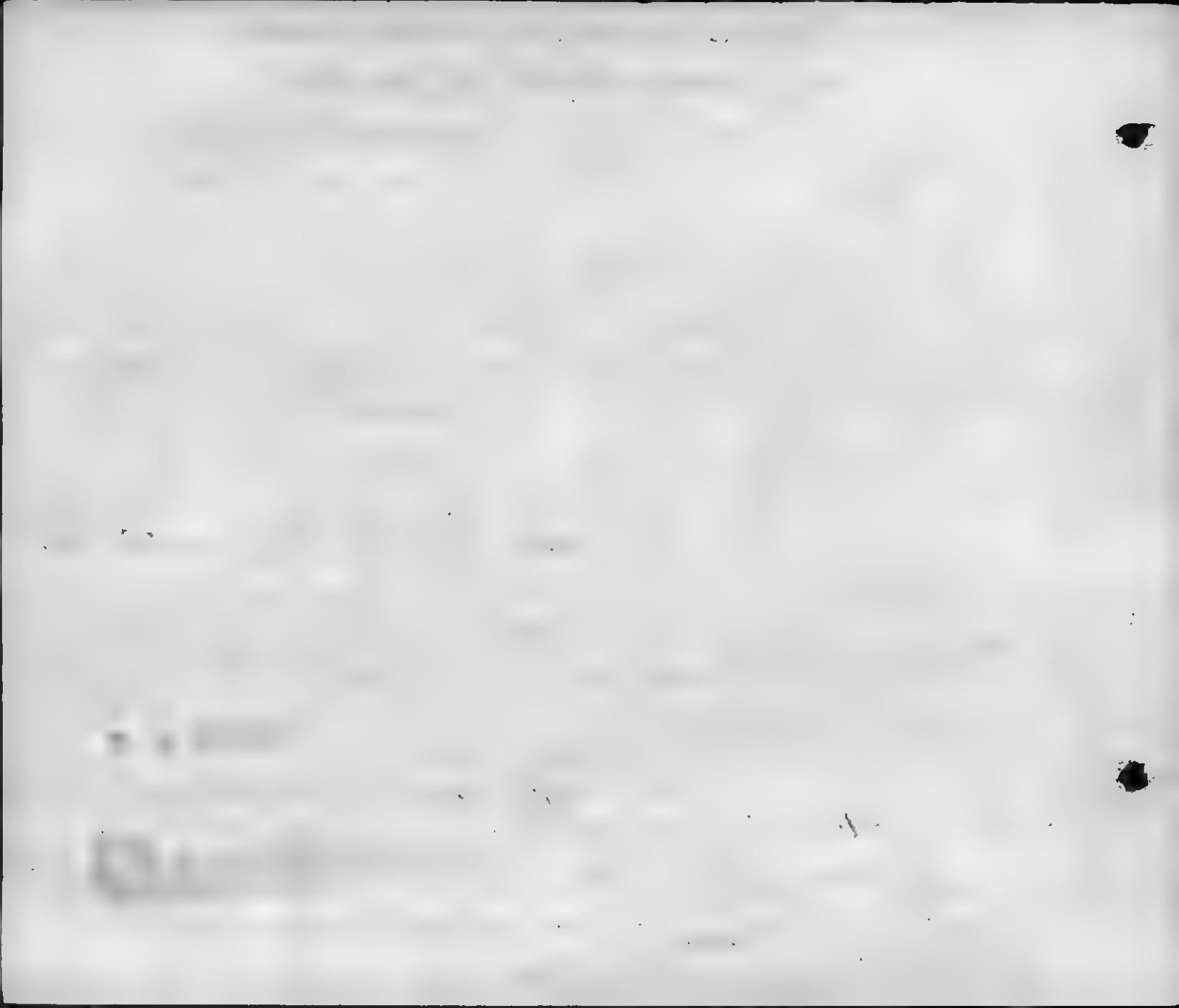
05745

5735

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>17 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Falesville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED (Type or Print) <u>LECI</u> (First) <u>Holland</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>June 10, 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 20 1886</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Shedyside</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Holland.</u>				14. MOTHER'S MAIDEN NAME <u>Emma Jane Livoss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u></u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
18a. IMMEDIATE CAUSE (A) <u>143X</u>				<u>Hypertensive Cardio-Vascular Disease 29 days</u>			
18b. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Nephrosclerosis</u>			
18c. STATING UNDERLYING CAUSE LAST.				<u>Uremia</u>			
19. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/16</u>, 19<u>56</u>, to <u>6/10</u>, 19<u>56</u>, that I last saw the deceased alive on <u>6/10</u>, 19<u>56</u>, and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Theodore H. Johnson M.D.</u>				DATE SIGNED <u>6/12/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/13/56</u>		NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>		LOCATION (City, town, or county) (State) <u>Falesville MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. O. Daniel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>			
DATE <u>6/13/56</u>							



5736

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Gen. Hosp. - (D.O.A.)				d. STREET ADDRESS -----			
3. NAME OF DECEASED (Type or print) First LILLIAN Middle B. Last HOLMES				4. DATE OF DEATH Month JUNE Day 23 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 25, 1887		9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months 5 Days 5 Hours 5 Min 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- U.S. Govt. Employee- Treasury Dept.				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME ----- Josetta				14. MOTHER'S MAIDEN NAME Elizabeth R. Josetta			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. Not Available		17. INFORMANT Frank Gutteridge, 2004-38th St. S.E., Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4/20/56 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Renal Disease DUE TO (c) -----						INTERVAL BETWEEN ONSET AND DEATH 3 mo. 8 yrs.	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 17, 1956 to June 23, 1956 , that I last saw the deceased alive on 17 June 1956 , and that death occurred at 1:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. B. Dason M.D.				ADDRESS (Street, city or town, state) Hypermarket Md DATE SIGNED 24-6-56			
PHYSICIAN'S NAME (Type) -----							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-27-56		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysong Co.				ADDRESS 1300 - N ST. N.W. Washington, D.C.		24a. REC'D BY REGISTRAR ----- DATE 25-6-56	
24b. REGISTRAR'S SIGNATURE John J. Forester							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 21

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5738

CERTIFICATE OF DEATH

05748

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>9 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, ANNAPOLIS</u>			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GERTRUDE ESTELLE IRELAND</u>				4. DATE OF DEATH Month Day Year <u>JUNE 16, 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 8 1947</u>	9. AGE (In years last birthday) yrs. <u>9</u>	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>St Margaretts A.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>HENRY WATKINS IRELAND</u>				14. MOTHER'S MAIDEN NAME <u>MARY LOUISE GRIMES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>mother - Same</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia, overwhelming</u> DUE TO <u>P.W. right arm.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fell injuring right arm - P.W.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>June 13 1956</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat while <input type="checkbox"/> at work			
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Annapolis, A.A., Md.</u>			
21. I certify that I attended the deceased from <u>June 16, 1956</u> , to <u>June 16, 1956</u> , that I last saw the deceased alive on <u>June 16, 1956</u> , and that death occurred at <u>6:10 P.M.</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Jesse L. Wilkins</u> M.D.				ADDRESS (Street, city or town, state) <u>98 Cathedral St., Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>JESSE L. WILKINS</u>				DATE SIGNED <u>6/16/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried June 21/56</u>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>				22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arnold A. Johnson</u>				ADDRESS <u>Annapolis</u>			
24a. REC'D BY REGISTRAR <u>Dr. Wm. J. French</u>				24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. J. French</u>			
DATE <u>6-19-56</u>							

5773

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH o. COUNTY <u>Ad. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Ad. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marley Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marley Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>202 Highland Rd.</u>				d. STREET ADDRESS <u>202 Highland Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Ellis</u> <u>Stupre</u>				4. DATE OF DEATH <u>6</u> / <u>9</u> / <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 16, 1916</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		10. UNDER 1 YEAR <u>6</u> Months <u>9</u> Days <u>19</u> Hours <u>56</u> Min.		11. BIRTHPLACE (State or foreign country) <u>City of Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ellis Stupre</u>				14. MOTHER'S MAIDEN NAME <u>Laura Stupre</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>10-10-10-10-10-10</u>			
17. INFORMANT <u>Dr. Hyster</u>				Address <u>202 Highland Rd. Marley Park</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO <u>1600X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHOGENIC CANCER OF LUNG</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>30 JAN</u> , 19 <u>56</u> , to <u>9 JUNE</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9 JUNE</u> , 19 <u>56</u> , and that death occurred at <u>6:42 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Main St. Elkridge, Md.</u> DATE SIGNED <u>10 JUNE 56</u>							
ACTUAL SIGNATURE <u>George E. Groleau</u>							
PHYSICIAN'S NAME (Type) <u>George E. Groleau</u> <u>Main St. Elkridge, Md.</u> <u>10 June 56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brownsville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Brownsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Brown</u>				ADDRESS <u>1001 Hollins St.</u>			
24a. REC'D BY REGISTRAR <u></u>				24b. REGISTRAR'S SIGNATURE <u>John J. Dealba</u>			
DATE <u>6-11-56</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5774 CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Anne Arundel	MARYLAND	STATE Maryland	COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) Rural - Laurel, Md.	LENGTH OF STAY (in this place) 28 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) Laurel, Md. (Rural)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School Laurel, Md.		STREET ADDRESS (If rural give location) Laurel, Md.	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
Earl Jackson (alias Jones) (Illeg.)		DATE OF DEATH: June 4 1956	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: Oct. 12, 1916
9. AGE last birthday: 39 yrs.		10. BIRTHPLACE (State or foreign country): Philadelphia, Pa.	
11. BIRTHPLACE (State or foreign country): Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Irving Jackson		14. MOTHER'S MAIDEN NAME: Alice Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): No		16. SOCIAL SECURITY NO.: None	
17. INFORMANT & ADDRESS: District Training School records			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Broncho pneumonia		2 days	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebro spasm. Mental Defective			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 3, 1956 , to June 4, 1956 , that I last saw the deceased alive on June 3, 1956 , and that death occurred at 5:45 A.M. from the causes and on the date stated above.			
SIGNATURE Francis M. Macintosh		DATE SIGNED June 5, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 6, 1956	
NAME OF CEMETERY OR CREMATORY District Training School		LOCATION (City, town, or county) (State) Laurel, Md.	
DATE REC'D BY LOCAL REGISTRAR June 5-56		24. FUNERAL DIRECTOR John J. Moore Jr.	
REGISTRAR'S SIGNATURE Robert H. Haskins		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1956

1956

1956

05750

5739

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY AA		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md		d. STREET ADDRESS 10 College Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Josephine Last JOHNS		4. DATE OF DEATH Month June Day 10 Year 1956			
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-80	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director		10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Field of 10 College Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 443 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertention DUE TO (c) Adrenal Cortical Adenoma		INTERVAL BETWEEN ONSET AND DEATH 434.1			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 17 May , 19 56 , to 10 June , 19 56 , that I last saw the deceased alive on 10 June , 19 56 , and that death occurred at 1122 M, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) USNH Annapolis, Md. DATE SIGNED 6-11-56					
ACTUAL SIGNATURE P.O. Geib M.D.					
PHYSICIAN'S NAME (Type) P.O. GEIB, CDR, MC, USN					
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial		6-13-56		Brewer Hill	
22d. LOCATION (City, town, or county)		(State)			
Annapolis		Md			
23. FUNERAL DIRECTOR'S SIGNATURE William. Keese - Annapolis, Md ADDRESS					
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
DATE 6-14-56		Dr. Wm. J. Lench			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

100-100000
100-100000

5740

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ind. General Hosp.</u>				d. STREET ADDRESS <u>133 Eastern Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Johnson</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wesley S. Park</u>				14. MOTHER'S MAIDEN NAME <u>Hickell, Sain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u> </u>		17. INFORMANT <u>Solomon Turner - 133 Eastern Ave.</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Diabetes Mellitus; Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Heart Failure</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>54</u> , to <u>June 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 17</u> , 19 <u>56</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Richardson</u>				ADDRESS (Street, city or town, state) <u>110 - Clay St. Annapolis, Md</u>			
DATE SIGNED <u>June 17, 1956</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
22b. DATE THEREOF <u>6-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Hill</u>		22d. LOCATION (City, town, or county) <u>Annapolis</u>		(State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>				ADDRESS <u>Annapolis, Md</u>		24a. REC'D BY REGISTRAR DATE <u>6-21-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. J. French</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dear Mr. [illegible]
 I have just received your letter of the 11th inst.
 and am glad to hear from you.
 I am well and hope this finds you the same.

Very truly yours,
 [illegible signature]
 11-12-11
 11-12-11
 11-12-11

5775

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 20yrs. 9mos. 17days		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. STREET ADDRESS 18 N. Mount Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rosie Middle Johnson Last Johnson		4. DATE OF DEATH Month 6 Day 24 Year 19 56		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Not known		9. AGE (In years last birthday) 74? yrs.		IF UNDER 1 YEAR Months — Days —		IF UNDER 24 HRS Hours — Min —		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Bertie Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Hospital Records		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricle failure		DUE TO (b) Myocardial infarction		DUE TO (c) lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Approx. 12 hrs.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from 1/21 , 19 48 , to 6/24 , 19 56 , that I last saw the deceased alive on 6/23 , 19 56 , and that death occurred at 5:10a. M., from the causes and on the date stated above.		DATE SIGNED 6/24/56	
ACTUAL SIGNATURE Ludwig Benedict		ADDRESS (Street, city or town, state) Crownsville, Md.		PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 6/29/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Med. School		22d. LOCATION (City, town, or county) Baltimore, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Katherine M. Joyce		24a. REC'D BY REGISTRAR Katherine M. Joyce		24b. REGISTRAR'S SIGNATURE Katherine M. Joyce	

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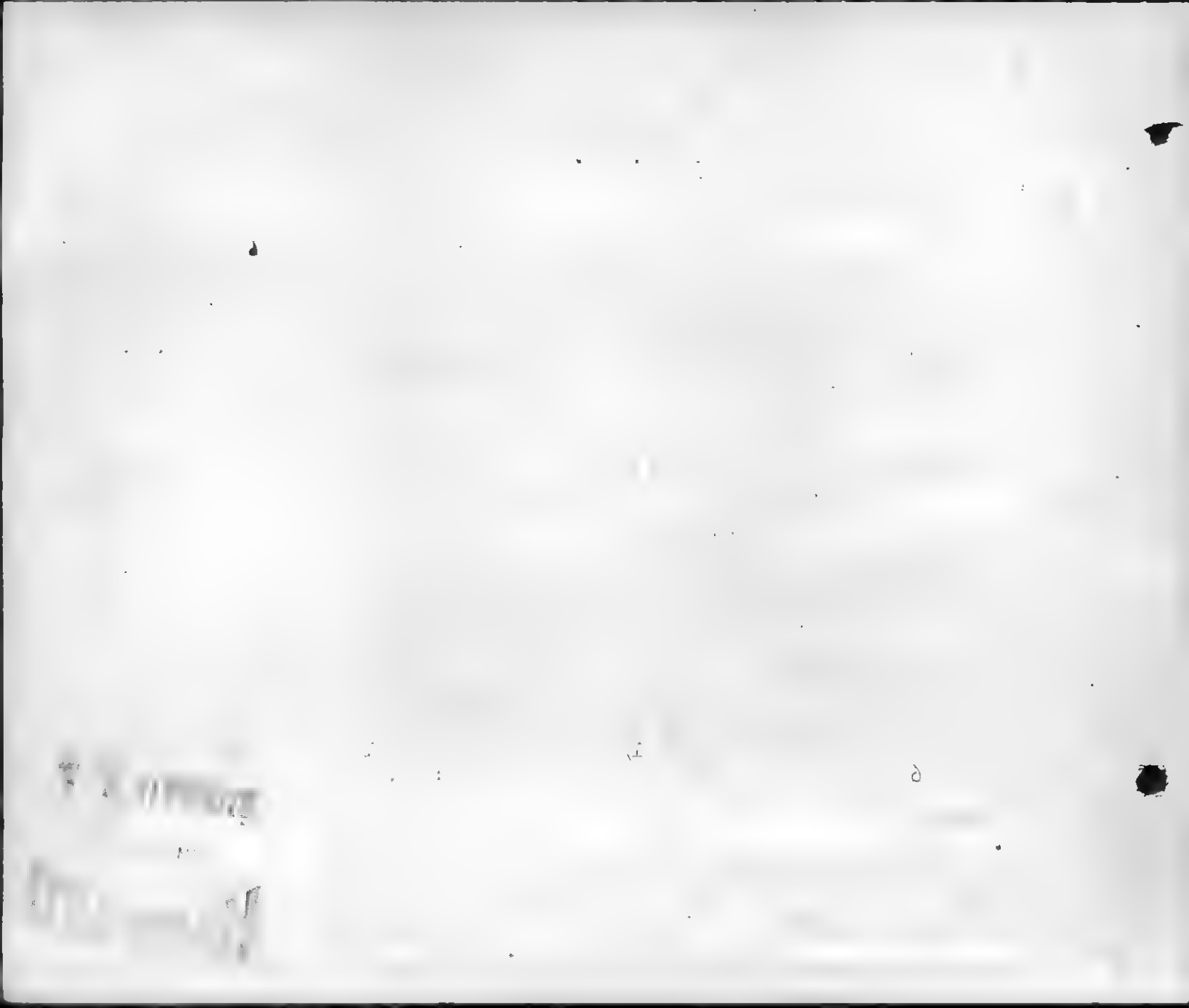
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5776
CERTIFICATE OF DEATH

05752

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 14yrs. 4mos. 24 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS Not known e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Keene Last Keene		4. DATE OF DEATH Month 6 Day 21 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1906?
9. AGE (In years last birthday) 50?		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months — Days — Hours — Min —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John H. Keene		14. MOTHER'S MAIDEN NAME Augusta Jane Travis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Kachexia DUE TO (c) Cancer of the intestines		INTERVAL BETWEEN ONSET AND DEATH 3 months 3 months Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple metastasis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. — p. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/21 , 19 48 , to 6/21 , 19 56 , that I last saw the deceased alive on 6/20 , 19 56 , and that death occurred at 1:45 a. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ludwig Benedict		ADDRESS (Street, city or town, state) Crownsville, Md.	
NAME (Type) Ludwig Benedict		DATE SIGNED 6/21/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/56	
22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital		22d. LOCATION (City, town, or county) (State) Crownsville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Hays		ADDRESS Crownsville, Md.	
24a. REC'D BY REGISTRAR 6-25-56		24b. REGISTRAR'S SIGNATURE K. M. Hays	



5777

CERTIFICATE OF DEATH

05753

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN 1b <u>10</u> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Kay</u> Last <u>Key</u>		4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1986</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-1883</u>
9. AGE (In years last birthday) <u>103</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
13. BIRTHPLACE (State or foreign country) <u>Lithonia, Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Shaw J. Howard</u>		16. MOTHER'S MAIDEN NAME <u>Sophia Key</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO. <u>213327103</u>	
19. INFORMANT <u>Charles H. Key</u>		Address <u>Lithonia, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Beltsville</u> , 19 <u>86</u> , to <u>Beltsville</u> , 19 <u>86</u> , that I last saw the deceased alive on <u>Beltsville</u> , 19 <u>86</u> , and that death occurred at <u>5:45</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emily H. Key</u> M.D. <u>acting in name</u>		ADDRESS (Street, city or town, state) <u>Lithonia, Md.</u> DATE SIGNED <u>6-27-86</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-30-86</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Lithonia, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Key</u> ADDRESS <u>Beltsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6/29/86</u>	
24b. REGISTRAR'S SIGNATURE <u>Elaine H. Key</u>			

1950-1951

NOF



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5778

CERTIFICATE OF DEATH

05754

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pt. Pleasant</u>		LENGTH OF STAY (in this place) <u>YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pt. Pleasant</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pt. Pleasant, Md. (Shoreland Rd.)</u>				STREET ADDRESS (If rural give location) <u>Shoreland Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>John Jefferson Klein</u>				4. DATE OF DEATH (Month) <u>6</u> (Day) <u>22</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>1/22/95</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Lewis Klein</u>				14. MOTHER'S MAIDEN NAME <u>Mary ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-10-5332</u>		17. INFORMANT & ADDRESS <u>Family Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<input checked="" type="checkbox"/> IMMEDIATE CAUSE (A) <u>Carcinoma, left lung & Metastasis.</u> ANTECEDENT CAUSE(S) DUE TO _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) _____ STATING UNDERLYING CAUSE LAST, DUE TO _____ (C) _____						<u>3 Mos.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-20</u> , <u>1956</u> , to <u>6-22</u> , <u>1956</u> , that I last saw the deceased alive on <u>6-22</u> , <u>1956</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above. SIGNATURE <u>William McDonald M.D.</u> ADDRESS <u>Eslen Burns M.D.</u> DATE SIGNED <u>6-22-56</u> M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/26/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. REC'D BY REGISTRAR <u>L. J. Sedlitz</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>MCCULLY FUNERAL HOME</u>		ADDRESS <u>130 E. Fort Ave.</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05755

5779

CERTIFICATE OF DEATH

Reg. Dist. No. 24

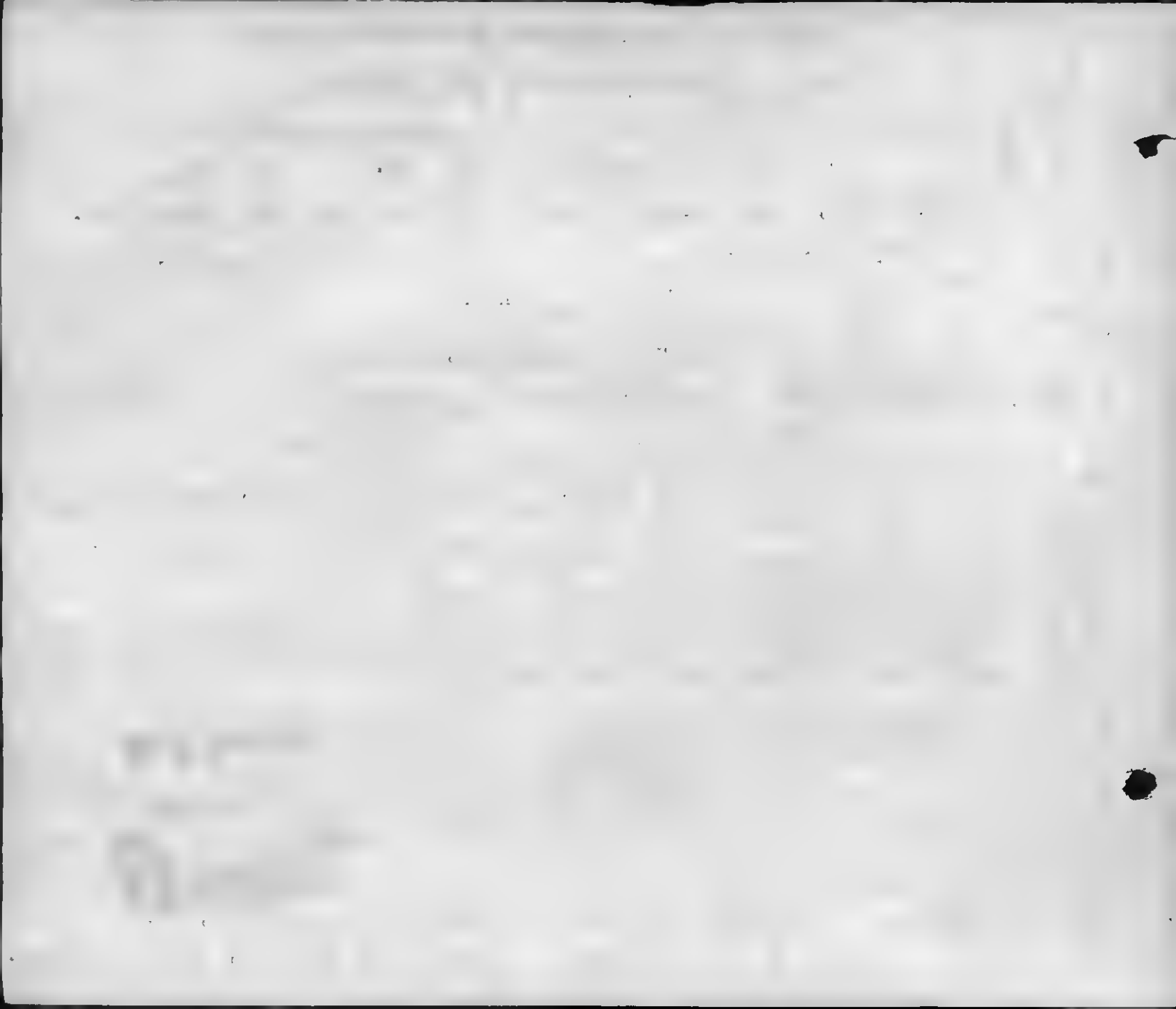
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY AA		MARYLAND		STATE Md.		COUNTY AA	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ferndale, Glen Burnie		LENGTH OF STAY (In this place) 3 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ferndale, Glen Burnie, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 21 Eugenia Ave				STREET ADDRESS 21 Eugenia Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Claude		(Middle) Kintz		(Last) Kline		(Month) 6 - (Day) 13 (Year) 1956	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH August 14, 1896	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meatcutter			10b. KIND OF BUSINESS OR INDUSTRY American Stores	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Israel Benjamin Kline				14. MOTHER'S MAIDEN NAME Ella Gaver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes WW I		16. SOCIAL SECURITY NO. 217 01 5710		17. INFORMANT & ADDRESS Mrs Violet Kline, same as 2			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) CORONARY THROMBOSIS						5 MIN.	
ANTECEDENT CAUSE(S) DUE TO CORONARY INSUFFICIENCY						22 MOS.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO CORONARY ARTERIOSCLEROSIS -							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-25, 1954, to 6-13, 1956, that I last saw the deceased alive on 6-13, 1956, and that death occurred at 8:00 P.M. from the causes and on the date stated above.							
SIGNATURE Leon C. Perry		DATE THEREOF 6/18/56		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/18/56		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Md.	
24. REC'D BY REGISTRAR DATE June 16, 1956		REGISTRAR'S SIGNATURE L. J. Dealba		25. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		ADDRESS Glen Burnie, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



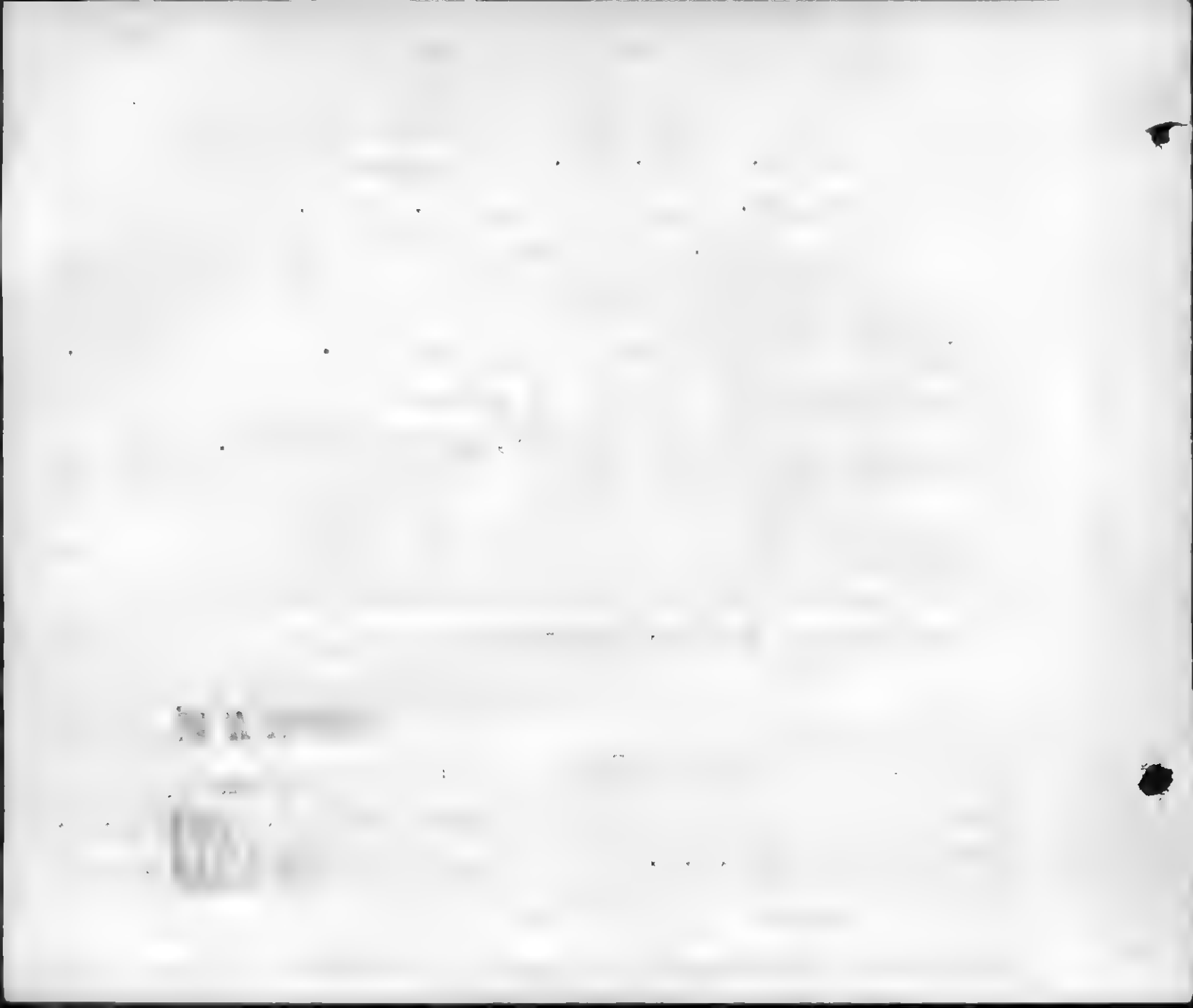
5780

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville State Hosp.				c. LENGTH OF STAY IN 1b 1 yr. 5 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hosp.				d. STREET ADDRESS 27 N. Carey St.			
3. NAME OF DECEASED (Type or print) Mattie A. Knox				4. DATE OF DEATH June 9 19 56			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH ?		9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Petersburg, Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Matthews				14. MOTHER'S MAIDEN NAME Catherine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Record, Crownsville State Hosp.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrenous right great toe, and mal-nutrition							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-1955 to 6-9-1956 , that I last saw the deceased alive on 6-9-1956 , and that death occurred at 1:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6-9-56 DATE SIGNED M.D. Crownsville State Hosp., Crownsville, Md.							
ACTUAL SIGNATURE <i>Ludwig Benedict</i>							
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		6/12/1956		St. Luke's Cemetery		Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Miss Katie R. Williams				ADDRESS 322 N. Schroeder St.		24a. REC'D BY REGISTRAR DATE 6-12-56	
						24b. REGISTRAR'S SIGNATURE <i>Katherine M. Joyce</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5741

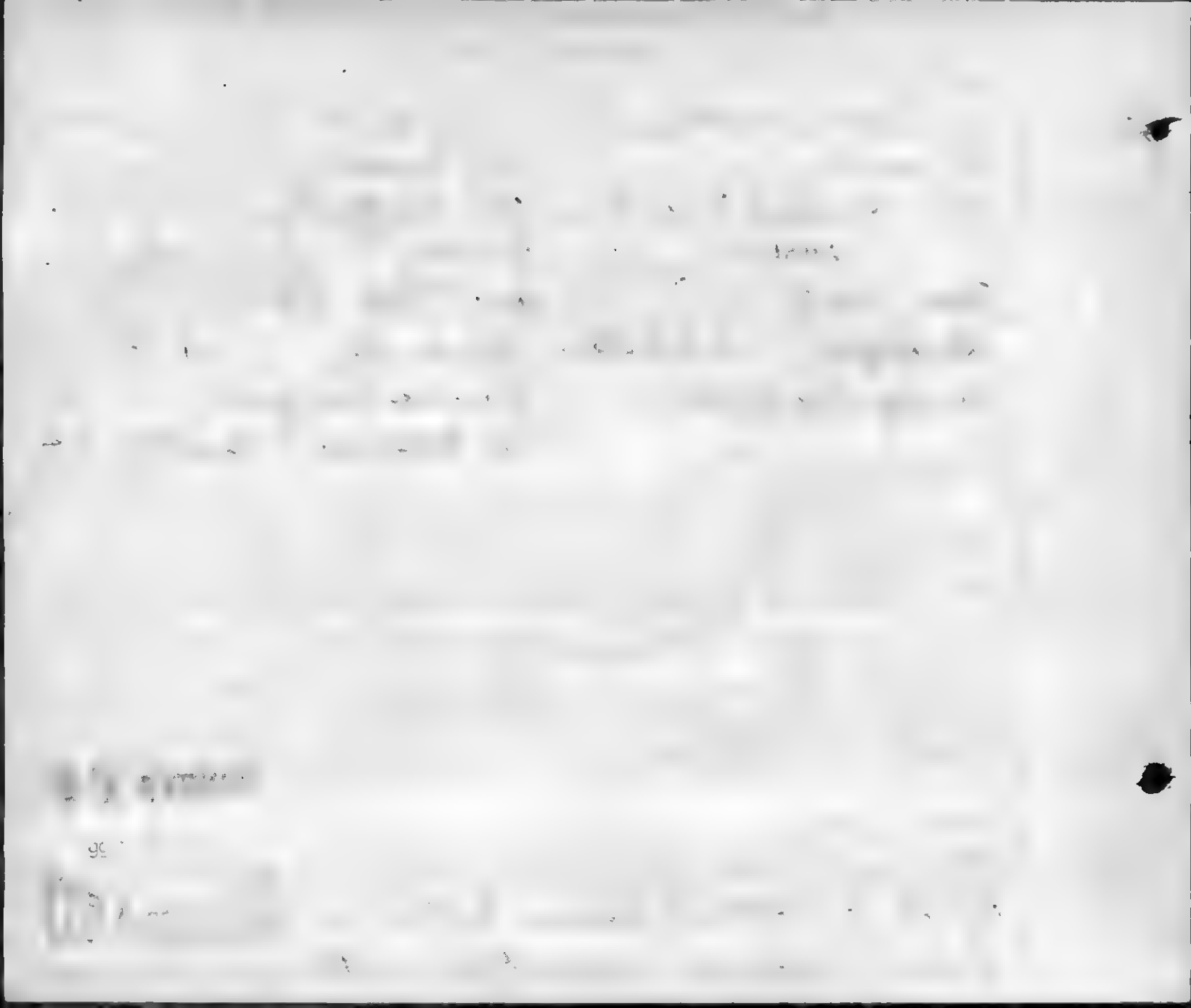
CERTIFICATE OF DEATH

05757

Reg. Dist. No. 2

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL OCCUPATION (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hospital</u>		d. STREET ADDRESS <u>412 Sixth St</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>H.</u> Last <u>KUTSCH</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3rd 1906</u>
9. AGE (In years and days) <u>50</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work in life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Store</u>	11. BIRTHPLACE (State or foreign country) <u>Phila. Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry Kutsch</u>	
14. MOTHER'S MAIDEN NAME <u>Amelia Crozier</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wife Madelyne E. Kutsch #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosis</u> DUE TO (c) <u>Arteriosclerotic nephrosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 mos</u> <u>15 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 1955, to <u>26 June</u> , 1956, that I last saw the deceased alive on <u>26 June</u> , 1956, and that death occurred at <u>12:53</u> P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>John R. Hildebrand</u> M.D. <u>90 Cathedral St. Annapolis, Md.</u>		DATE SIGNED <u>6/26/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-29-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a. REC'D BY REGISTRAR <u>John M. Taylor</u>	
24b. DATE <u>6/27/1956</u>		24c. REGISTRAR'S SIGNATURE <u>John M. Taylor</u>	

YS A15 (4)
19/9/55



5742

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>79 Shipwright St.</u>			
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>WARREN</u> Last <u>LAJEUNESSE</u>				4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-27-1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. UNDER 1 YEAR		11. IF UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Pearl Admiral U.S. NAVY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u>		11. BIRTHPLACE (State or foreign country) <u>N. NEW PORTLAND ME.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Verne Lashness</u>				14. MOTHER'S MAIDEN NAME <u>Marguerite Paige</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1924</u>				16. SOCIAL SECURITY NO. <u>1924</u>			
17. INFORMANT <u>Dorothy M. Lajeunesse</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic hypertension</u> (c) <u>Thrombotic hypertension</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>7 min.</u> <u>2 yrs.</u> <u>2 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/3</u> , 19 <u>56</u> , to <u>6/3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/3</u> , and that death occurred at <u>2:20</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>90 Cathedral St. Annapolis Md.</u> DATE SIGNED <u>6/3/56</u>							
ACTUAL SIGNATURE <u>John H. Haden</u>				PHYSICIAN'S NAME (Type) <u>Annapolis Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-5-56</u>		<u>Naval Academy Cemetery</u>		<u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				24a. REC'D BY REGISTRAR <u>6/4/1956</u>			
ADDRESS <u>Sun Annapolis Md.</u>				24b. REGISTRAR'S SIGNATURE <u>V. Daniel</u>			

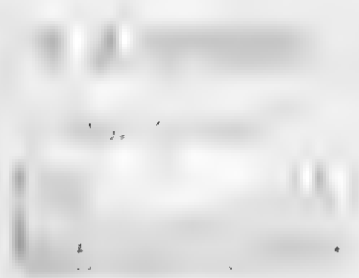
U.S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS West Street (Presto Hotel)			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF WILLIAM First MARTIN Middle LAUSCH Last				4. DATE OF DEATH JUNE 15, 1956 Month 15 Day 19 Year 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1917	
9. AGE (In years last birthday) 39 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Building construction		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William C. Lausch				14. MOTHER'S MAIDEN NAME Ida Hittle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO 216-18-7943		17. INFORMANT Mr. John J. Lausch- Brother- Annapolis, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acc. Pulmonary embolism & electro DUE TO Electrolyte imbalance Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 wk. DUE TO 1st Exhaustion & extreme prostration 14/6/56 (c) 1 wk.				INTERVAL BETWEEN ONSET AND DEATH 1 wk.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No further information			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Annapolis				20g. (County) Anne Arundel		20h. (State) Md.	
21. I certify that I attended the deceased from June 14, 1956 to June 15, 1956 , that I last saw the deceased alive on June 14, 1956 , and that death occurred at 1:43 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Maurice F. Klawans				ADDRESS (Street, city or town, state) Annapolis, Md.			
PHYSICIAN'S NAME (Type) Maurice F. Klawans				DATE SIGNED June 18, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 19, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR June 18, 56	
				24b. REGISTRAR'S SIGNATURE J. J. Lausch			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be received by a hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5781

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05760

Reg. Dist.

No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>A.A. County</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>A.A. CO.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Rural</u>				TOWN <u>RURAL - MAYO</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>Clowery</u> Box <u>24</u>			
3. NAME OF DECEASED: (First) <u>NORMAN</u>		(Middle) <u>W.</u>		(Last) <u>LEE</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>17</u> (Year) <u>1956</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M.</u>	8. DATE OF BIRTH: <u>Oct. 10, 1899</u>		9. AGE last birthday: <u>56</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Coal Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Coal</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William J. Lee</u>				14. MOTHER'S MAIDEN NAME: <u>Lilla Lushy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>1919</u>		16. SOCIAL SECURITY No.: <u>220-03-5171</u>		17. INFORMANT & ADDRESS: <u>Mrs. Dorothy Lee- Wife- same as # 2</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				Sudden	
Immediate cause (a) <u>Chronic Myocarditis</u>					
DUE TO					
Antecedent cause(s) (b) <u>DUE TO</u>					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>E. H. Smith</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-16-56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>20-56</u>	NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>	LOCATION (City, town, or county) (State) <u>Fairfax County, Virginia</u>		
DATE REC'D BY LOCAL REG. <u>6-18-56</u>	RECEIVED BY SIGNATURE <u>J. O. Daniel</u>	24. FUNERAL DIRECTOR <u>HOPKINS FUNERAL HOME</u> ADDRESS <u>Annapolis, Md.</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5744

CERTIFICATE OF DEATH

05761

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hosp.		e. STREET ADDRESS 106 Eastern Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last William Henry Clay Lewis		4. DATE OF DEATH Month Day Year June 25, 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1869
9. AGE (In years last birthday) yrs. 86		10. IF UNDER 1 YEAR Months Days Hours Min. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Carpenter		10b. KIND OF BUSINESS OR INDUSTRY CAARPENTER	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Henry Lewis		14. MOTHER'S MAIDEN NAME Melvine Sewel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes U.S.N.		16. SOCIAL SECURITY NO. U.S.N.	
17. INFORMANT Lawrence Albert Lewis		Address 211 Eastern Ave. Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO (b) anesthesia, operation (debridement of burn), (c) pneumonia, generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Third degree burns thighs, rt. leg; expired under anesthes		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell down steps and spilled scalding water on self.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. May 18 1956 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Annapolis, A.A., Md.	
21. I certify that I attended the deceased from May 18, 1956 , to June 25, 1956 , that I last saw the deceased alive on June 25, 1956 , and that death occurred at 10:33AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jesse L. Wilkins		ADDRESS (Street, city or town, state) DATE SIGNED 98 Cathedral St., Annapolis, Md.	
PHYSICIAN'S NAME (Type) Jesse L. Wilkins			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/27/56	
22c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF		22d. LOCATION (City, town, or county) (State) Annapolis Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. K. & S. Annapolis, Md.		24. REC'D BY REGISTRAR June 27, 1956	

BUENOS AIRES

1914

1914

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5745

CERTIFICATE OF DEATH

Reg. Dist. No.

05762

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospt.</u>		d. STREET ADDRESS <u>Truxton Heights</u>	
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>L.</u> Last <u>Lipinski</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-18-1900</u>
9. AGE (In years, last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francis Lipinski</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Kwiatkowski</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Helen V. Lipinski</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>524X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>anthracosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3d</u> <u>3+ yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1953</u> , to <u>6/8/1956</u> , that I last saw the deceased alive on <u>6/8/1956</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D. <u>63 College Ave</u>		DATE SIGNED <u>6/9/56</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-11-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Laybort-Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-11-56</u>	24b. REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05763

Reg. Dist. No. 24

5782

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>417 Delmar Avenue</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Ella Lookerman</u>				4. DATE OF DEATH <u>June 27th, 19 56</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9/24/03</u>	
9. AGE (in years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Restaurant Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Operator</u>		11. BIRTHPLACE (State or foreign country) <u>Lake Shore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Jubb</u>				14. MOTHER'S MAIDEN NAME <u>Effie L. Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>215-14-5575</u>		17. INFORMANT <u>Mrs. R. Grosser, 318 Murdock Rd. Towson, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage caused by a self inflicted</u> <u>176X</u> DUE TO <u>wound through the brain with a 38 calibre bullet.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Deceased shot herself through the right temporal with a bullet.</u>					
20c. TIME OF INJURY Month, Day, Year <u>9:55 A.M. 6/27/56 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home (bed room)</u>		20f. (City or town) (County) (State) <u>Glen Burnie Md. A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/27/56</u>			
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF <u>June 29, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Deane</u>				24a. REC'D BY REGISTRAR <u>L. J. Deane</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Deane</u>	
ADDRESS <u>Glen Burnie, Md.</u>				DATE <u>July 2, 1956</u>			

11/1/1940

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5783

CERTIFICATE OF DEATH

05764

Reg. Dist. No. X3

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Linthicum Hgts.</u>	LENGTH OF STAY (in this place) <u>9 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Linthicum Hgts.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>117 Sycamore Rd.</u>		STREET ADDRESS (If rural give location) <u>117 Sycamore Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Patrick Joseph Lasco</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 3, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 8, 1900</u>
9. AGE last birthday <u>56</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Universal Refining Corp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Brooklyn, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Lasco</u>		14. MOTHER'S MAIDEN NAME <u>Angelina Sippolini</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>109-09-3225</u>	
17. INFORMANT & ADDRESS <u>Mrs. Marguerite H. Lasco Linthicum</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
IMMEDIATE CAUSE (A) <u>Carcinoma of the Cecum with</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 mo.</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>metastases</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1, 1956</u> , to <u>June 3, 1956</u> , that I last saw the deceased alive on <u>June 3, 1956</u> , and that death occurred at <u>4:00 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>C. Miller Linthicum</u>		ADDRESS (Street, city, town, state) <u>M.D. 106 W. Maple Rd. Linthicum Hgts. Md.</u>	
DATE SIGNED <u>6/3/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 7, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Stone Fort Cemetery</u>	LOCATION (City, town, or county) (State) <u>Schoharie, New York</u>
24. REC'D BY REGISTRAR <u>6/6/56</u>	REGISTRAR'S SIGNATURE <u>Dr. Caldwell Woodruff</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn Burnie</u>	ADDRESS <u>Md.</u>



INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

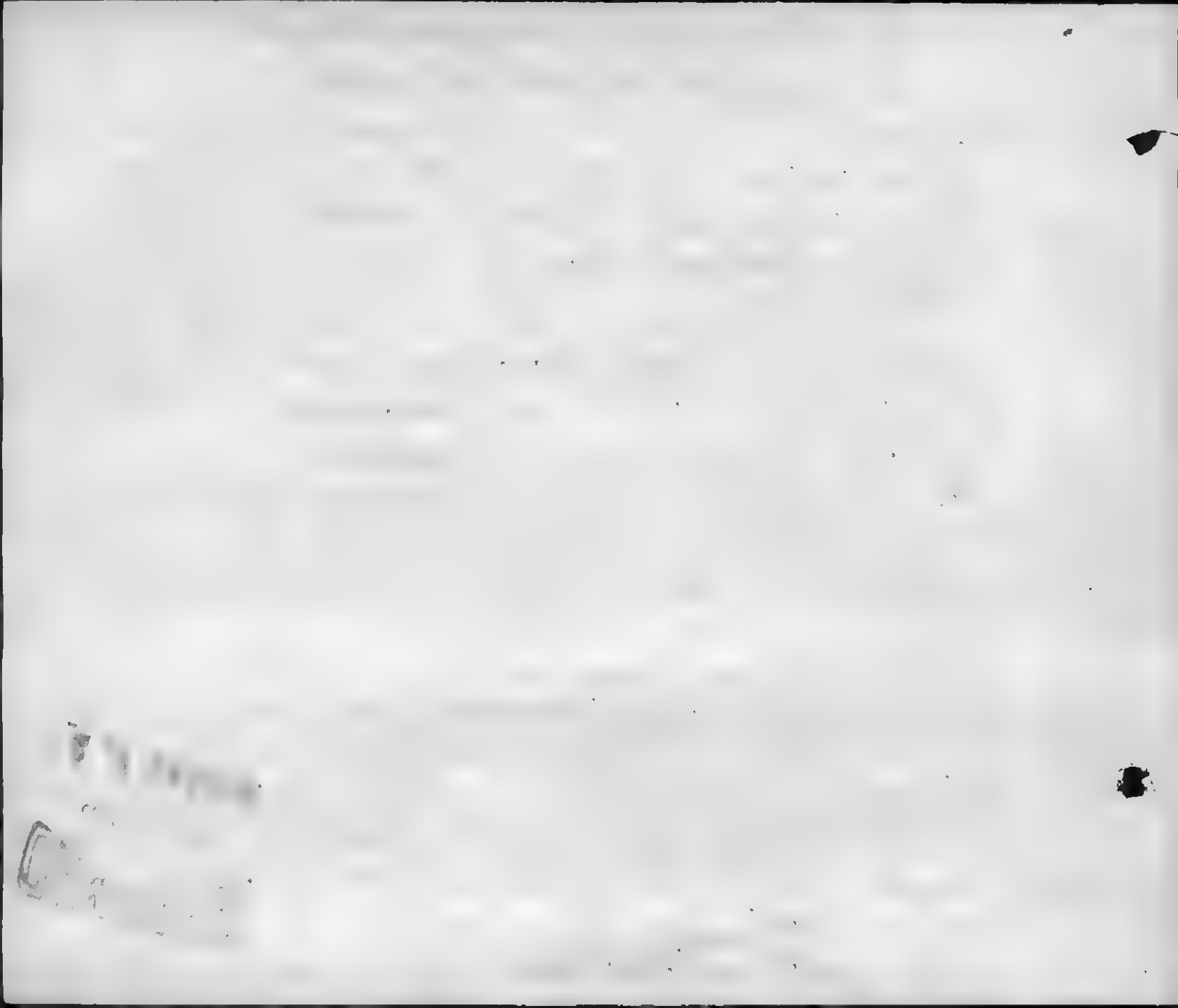
05765

CERTIFICATE OF DEATH

Reg. Dist. No. 21

5746

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anna Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anna Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anna Arundel General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>SADIE</u> (First) <u>MARCELLAS</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>June 24</u> 19 <u>56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 6, 1894</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Owings, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James S. Catterton</u>				14. MOTHER'S MAIDEN NAME <u>Rose Chaney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Clarence Marcellas, same as #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cerebrovascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>hypertension.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>droplets mellitus; fruit at hips</u>							
19a. DATE OF OPERATION <u>6/6/56</u>		19b. MAJOR FINDINGS OF OPERATION <u>intestine hemorrhage rupture at hips</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Wheaton, Annapolis Md</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>2000h 6/6/56 M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>fell.</u>			
22. I hereby certify that I attended the deceased from <u>Jan 55</u> , 19 <u>55</u> , to <u>June 24, 1956</u> , that I last saw the deceased alive on <u>June 23, 1956</u> , and that death occurred at <u>4:57 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Annapolis, Md</u>		DATE SIGNED <u>6/24/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/26/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Harmony</u>		LOCATION (City, town, or county) (State) <u>Owings Md</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REC'D BY REGISTRAR <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
DATE <u>6/25/56</u> <u>6/28/56</u>							

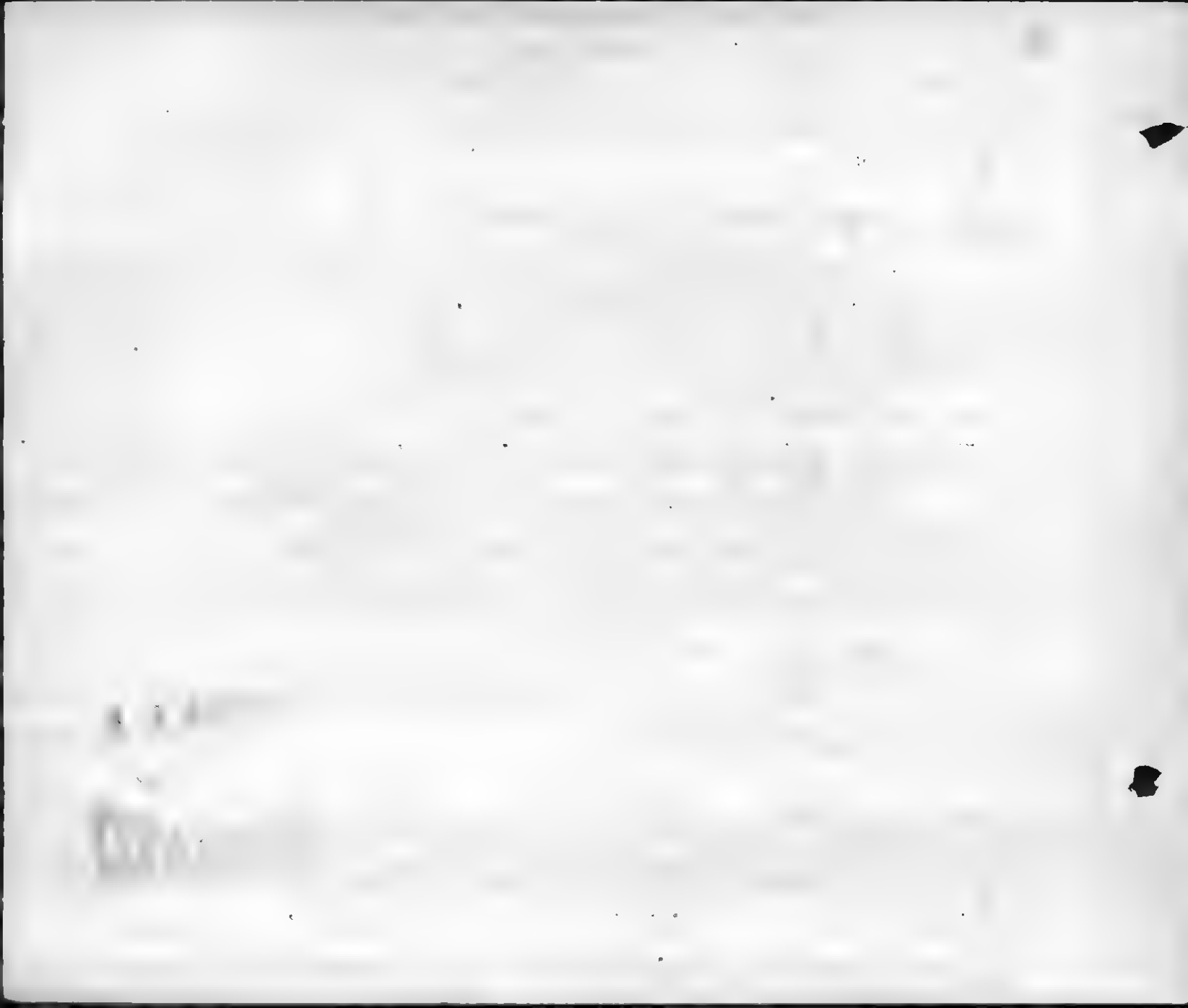


5784

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bayside Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bayside Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Harbor Road		d. STREET ADDRESS 22 Harbor Road	
3. NAME OF DECEASED (Type or print) First ICIE (IDA) Middle MAY Last MARTIN		4. DATE OF DEATH Month June Day 16 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1872
9. AGE (In years last birthday) yrs. 83		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William C. Kisner		14. MOTHER'S MAIDEN NAME Hannah Singleton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. none	
17. INFORMANT Edna R. Streett, 22 Harbor Road, Bayside Beach, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac decompensation 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c) not known		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1956 to June 16, 1956 that I last saw the deceased alive on June 15, 1956 , and that death occurred at 6:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R.M. McLaughlin M.D.		ADDRESS (Street, city or town, state) Pasadena, Md. DATE SIGNED June 16, 1956	
PHYSICIAN'S NAME (Type) R.M. McLAUGHLIN, M.D.		Pasadena, Md. June 16, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6/20/56	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. C. Mc		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR DATE 6-19-56		24b. REGISTRAR'S SIGNATURE Louis J. DeAlba	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5747 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05767

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Matthew</u> Last 4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1956</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>3-25-56</u> 9. AGE (In years last birthday) yrs. <u>2</u> Months <u>2</u> Days <u>28</u> Hours <u></u> Min. <u></u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S I</u>				13. FATHER'S NAME <u>Charles Matthew</u> 14. MOTHER'S MAIDEN NAME <u>William Griffin</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT <u>William Griffin</u> Address <u>Annapolis, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>921.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Apnea Vomitus</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u></u> o. m. <u></u> p. m. <u></u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type) <u>B. LINHARDT</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>6-26-56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u> 22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>William Griffin</u> ADDRESS <u>Annapolis, Md</u> 24a. REC'D BY REGISTRAR <u>Jan 27, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 6 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U.S. DEPT. OF JUSTICE

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5785

CERTIFICATE OF DEATH

05768

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 5 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle McDonald Last McDonald		4. DATE OF DEATH Month 6 Day 19 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/26/07
9. AGE (In years last birthday) 48 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Not given S.C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given Jesse McDonald		14. MOTHER'S MAIDEN NAME Not given Eddie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Hospital Records		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Toxemia IMMEDIATE CAUSE (a) — DUE TO (b) Multiple necrotic trophic ulcers of the skin DUE TO (c) Central Nervous System Syphilis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour — a. p. — p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/17 , 19 56 , to 6/19 , 19 56 that I last saw the deceased alive on 6/18 , 19 56 , and that death occurred at 1:45 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ludwig Benedict		DATE SIGNED 6/19/56	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.		ADDRESS (Street, city or town, state) Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 6/22/1956	
22c. NAME OF CEMETERY OR CREMATORY Western Star		22d. LOCATION (City, town, or county) (State) Calumville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie K. Williams		24. REGISTRAR'S SIGNATURE Katherine M. Joyce	
ADDRESS 322 N. Schroeder Baltimore, Md.		No. REC'D BY REGISTRAR 6-21-06	

J. A. FARMER

1871

Reg. Dist. No. **05768** ✓

1 PLACE OF DEATH a. COUNTY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Rural Box 23 C	
3. NAME OF DECEASED (Type or print) First EUGENE Middle H. Last McINTYRE, SR.		4. DATE OF DEATH Month June Day 28, Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1900
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian Officer		10b. KIND OF BUSINESS OR INDUSTRY Md. Penal Institution Md.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James F. McIntyre		14. MOTHER'S MAIDEN NAME Mary Gertrude McIntyre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. World War 1 & 2 none	
17. INFORMANT Mrs. Gertrude L. McIntyre - Rural Box 23 C		Address Jessups, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis of throat + tongue DUE TO Causes of tonsil. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 6 mos DUE TO (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 1st 19 56 to June 28, 1956 that I last saw the deceased alive on June 28, 1956 and that death occurred at 2 1/2 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank E. Shipley		ADDRESS (Street, city or town, state) Savage, Md.	
PHYSICIAN'S NAME (Type) Frank E. Shipley		DATE SIGNED 6/28/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/2/56	22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickers & Sons - Balto 17 N. E. Ave.			
24a. REC'D BY REGISTRAR DATE June 30 1956		24b. REGISTRAR'S SIGNATURE R. H. ...	

RECEIVED

SEP 2 1956

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05770

5787

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY <u>Ft. Meade</u>		CITY <u>Ft. Meade</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Ft. Meade</u>		<u>5 1/2 hrs</u>		TOWN <u>Ft. Meade</u>		TOWN <u>Ft. Meade</u>	
HOSPITAL OR INSTITUTION, OR STREET ADDRESS <u>U.S.A.H. Ft. Meade</u>				STREET ADDRESS (If rural give location) <u>US ARMY HOSPITAL</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>CHARLES - MEYERS</u>				<u>June 28</u>		<u>1956</u>	
SEX <u>Male</u>		COLOR OR RACE <u>White</u>		DATE OF BIRTH <u>27 June 1956</u>		AGE last birthday <u>5 hr 30 min</u>	
SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HOWARD M. MEYERS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH L. KELLY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>none</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Father: 1106 S. Highland Ave., Balto., Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Prematurity</u>				<u>PREMATURITY</u>		<u>5hrs 30 min</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>27 June 1956</u> to <u>28 June 1956</u> that I last saw the deceased <u>alive on 28 June 1956</u> and that death occurred at <u>3:00 AM</u> from the causes and on the date stated above. SIGNATURE <u>Michael A. Dobridge</u> DATE SIGNED <u>28 June 56</u> ADDRESS <u>1201 Disney Dr, Silver Spring, Md.</u> LOCATION FOR SIGNATURE <u>BALTO., Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>28 June 56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>		LOCATION FOR SIGNATURE <u>BALTO., Md.</u>	
24. REC'D BY REGISTRAR <u>28 June 56</u>		REGISTRAR'S SIGNATURE <u>W.L. SAYLOR, 1/Lt MSC</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>WM. S. FIALKOWSKI, BALTO., Md.</u>		ADDRESS	

RECEIVED
JAN 21 1962

5748

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>AA County</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HUNTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>3808 13th St - BROOKLYN - MD</u>		b. COUNTY <u>MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN - MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>D. O'NEILL HUNTSVILLE GENERAL</u>						d. STREET ADDRESS <u>3808 3RD ST.</u>							
3. NAME OF DECEASED (Type or print)		First <u>Joseph</u>		Middle <u>D. MIGLIORINI</u>		Last <u></u>		4. DATE OF DEATH		Month <u>June</u> Day <u>8</u> Year <u>1986</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 27, 1898</u>		9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min <u></u>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DAVIDSON CHEMICAL</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>DOMINIC MIGLIORINI</u>						14. MOTHER'S MAIDEN NAME <u>LUCIA FURLENI</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>215-07-7527</u>		17. INFORMANT <u>VINCENT MIGLIORINI, 320 WASHBURN AVE</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart disease</u> 434.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>JUNE 8</u> , 19 <u>86</u> , to <u>JUNE 8</u> , 19 <u>86</u> , that I last saw the deceased alive on <u>JUNE 8</u> , 19 <u>86</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above.													
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>[Address]</u>				DATE SIGNED <u>[Date]</u>					
PHYSICIAN'S NAME (Type) <u>E. LINHARDT</u>				M.D. <u>[Signature]</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/11/86</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>				22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Jones</u>				ADDRESS <u>4001 RITCHIE HWY</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5788

CERTIFICATE OF DEATH

Reg. Dist. No.

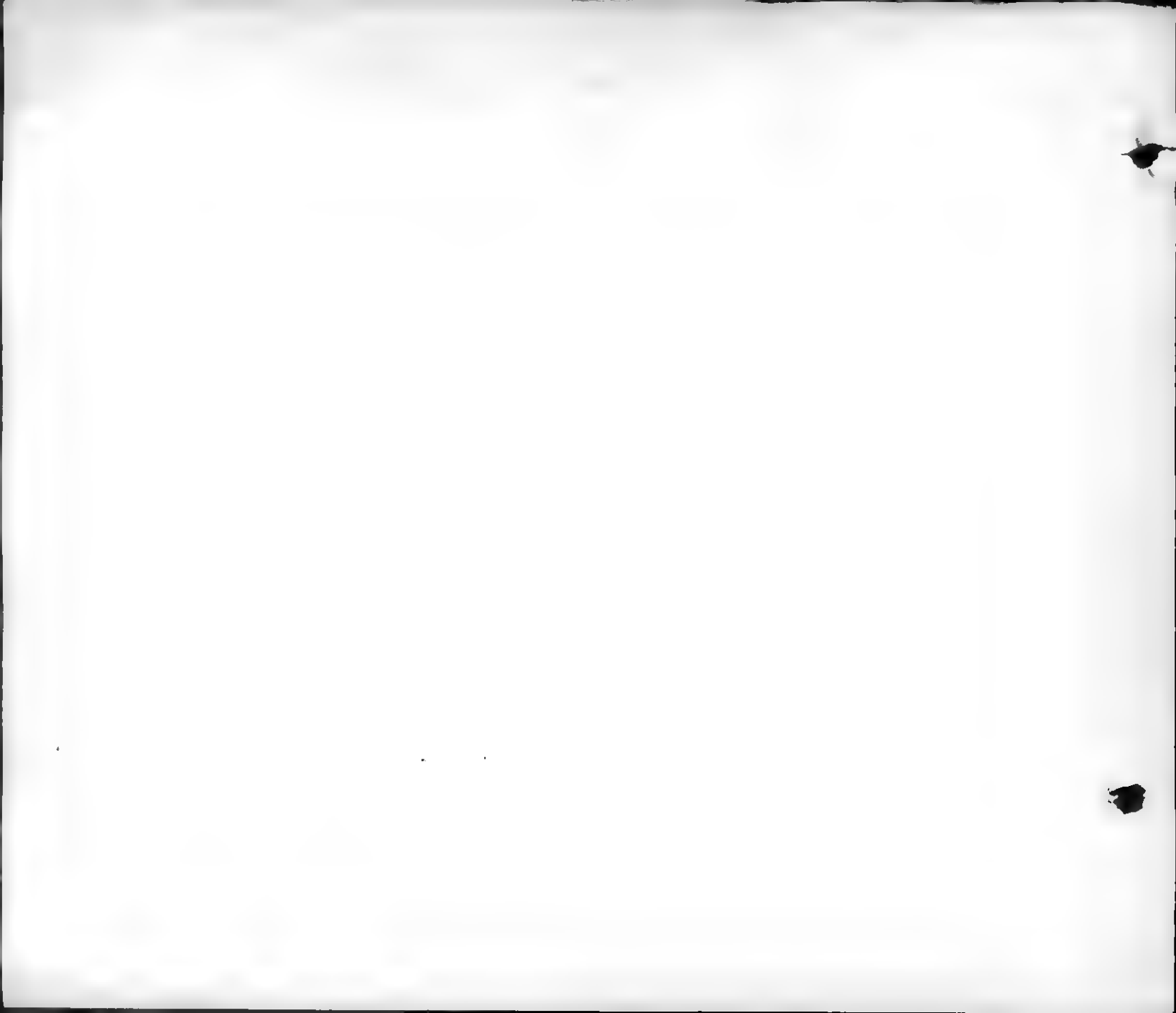
ly. The
7.
correct age is especially.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAIN UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) VINCENZO MOSCO <i>Vincenzo Moser</i>			2. DATE OF DEATH 6/6/56		
3. PLACE OF DEATH A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. COUNTY Anne Arundel		
B. FULL NAME OF HOSPITAL OR INSTITUTION 422 Church Street			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 85		
D. STREET ADDRESS (If rural, give location) 422 Church St			E. STREET ADDRESS (If rural, give location)		
c. Length of stay in Baltimore Yrs. Yrs. Mos. Mos. Days Days			D. STREET ADDRESS (If rural, give location)		
5. SEX m.	6. COLOR OR RACE w.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 5.19.1886		9. AGE (in year last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stone mason			10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Italy
13. FATHER'S NAME antonio Moser M 300			14. MOTHER'S MAIDEN NAME alvina Polairri		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no			16. SOCIAL SECURITY NO. 206-05-8609		
17. INFORMANT Chiara Moser - name			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I Coronary Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 2 hr		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Total Heart Block (Adams Stokes)			DUE TO 9 months		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coronary sclerosis			DUE TO e		
19A. DATE OF OPERATION 0			19B. MAJOR FINDINGS OF OPERATION Coronary sclerosis		
20. AUTOPSY? no			21. SIGNATURE H. S. Summers		
22. I hereby certify that I attended the deceased from Sept. 1956 to June 5, 1956 that I last saw the deceased alive on June 4, 1956 and that death occurred at 345 years, from the causes and on the date stated above.			23. ADDRESS 110106 Yappa Ave		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial			24B. DATE 6/8/56		
24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.			24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.		
DATE RECEIVED BY LOCAL REGISTRAR 6-7-56			REGISTRAR'S SIGNATURE Dr. Hedrick		
25. FUNERAL DIRECTOR McCully Funeral Hm. 130 E. Fort Ave.			ADDRESS		



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05772

Item 8, Film 198 6-18-56 et

CERTIFICATE OF DEATH

5749

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		STATE <u>MD</u>		COUNTY <u>CC</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		LENGTH OF STAY (In this place) <u>62 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. C. General</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Russell</u> (First) <u>Moreland</u> (Middle) <u></u> (Last)				4. DATE OF DEATH <u>June 9</u> (Month) <u>1956</u> (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 7 1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		11. BIRTHPLACE (State or foreign country) <u>Bristol Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>W. M. E. Moreland</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA ELLEN MORELAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Mary S Moreland, Bristol Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4. IMMEDIATE CAUSE (A) <u>Cerebral embolus</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 28</u> , 19 <u>56</u> , to <u>June 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 8</u> , 19 <u>56</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Emily H. Wilson</u>				ADDRESS (Street, city, town, state) <u>Lothian, Md.</u>		DATE SIGNED <u>6/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/10/56</u>		NAME OF CEMETERY OR CREMATORY <u>West Zion</u>		LOCATION (City, town, or county) <u>Lothian Md</u>	
24. REC'D BY REGISTRAR <u>J. J. - J. J. - J. J.</u>		REC'D BY REGISTRAR <u>J. J. - J. J. - J. J.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardy</u>		ADDRESS <u>Lothian Md</u>	
DATE <u>6-13-1956</u>							



5789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH a. COUNTY <u>Prince Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>New Cut Road</u>			d. STREET ADDRESS <u>New Cut Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kenneth Long Mumford</u>			4. DATE OF DEATH Month Day Year <u>June 9th. 1956</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/11</u>		9. AGE (In years last birthday) <u>44</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Philadelphia Penn.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Mumford</u>			14. MOTHER'S MAIDEN NAME <u>Julia King</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes Navy 1942-45</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Alma Mumford (Wife.)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>449.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Gustave H. Paulsen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Paulsen M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>June 10/1956</u>	
22a. BURIAL, CREMATORY, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/12/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cem.</u>		22d. LOCATION (City, town, or county)	(State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>		ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>6-13-56</u>	24b. REGISTRAR'S SIGNATURE <u>Clara Haslop</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4 3 Avenue

12

5750

CERTIFICATE OF DEATH

05774

Reg. Dist. No. 21

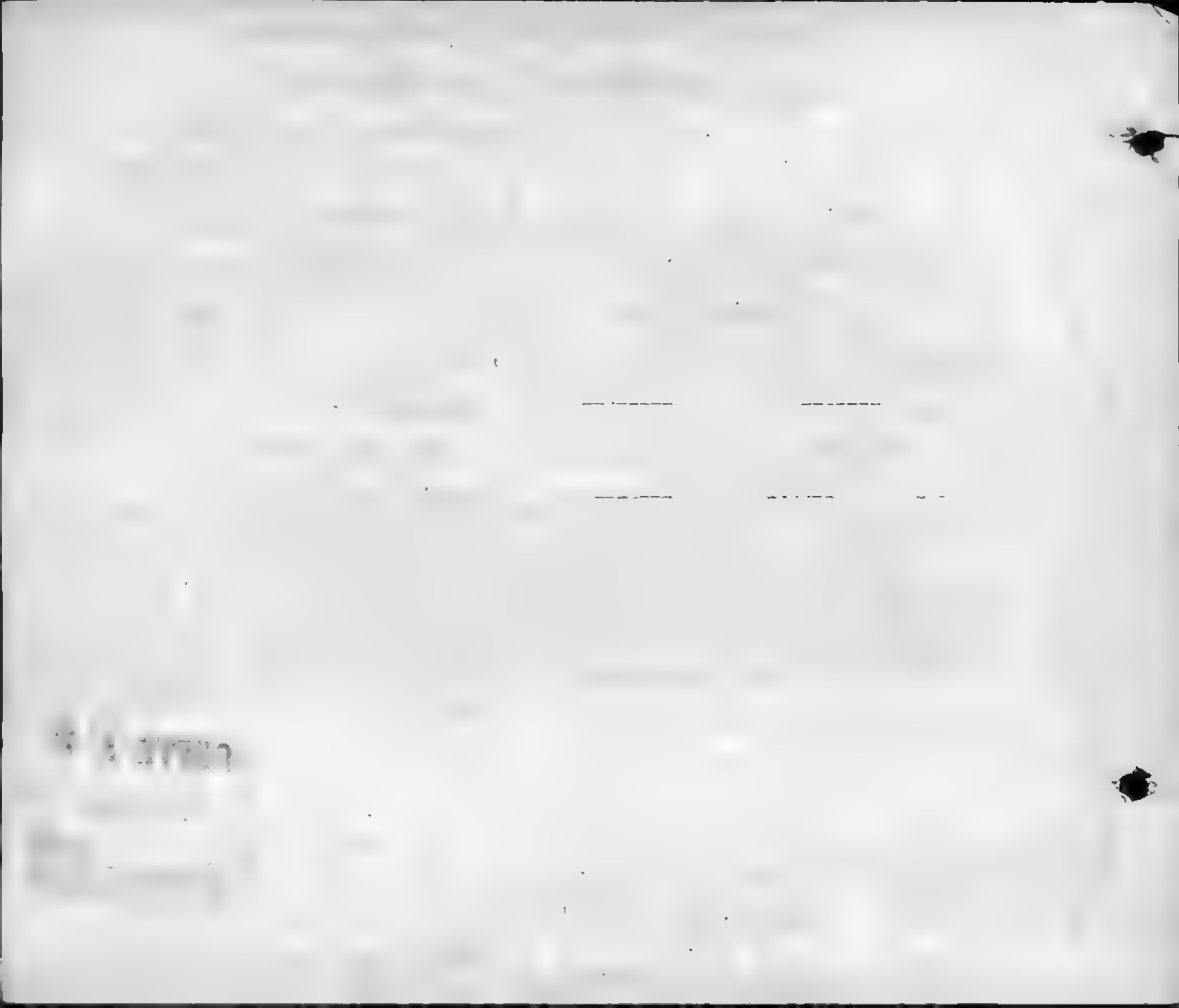
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>				STREET ADDRESS (If rural give location) <u>5 Dale Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>Catherine Norman</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 19 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 18, 1956</u>	9. AGE last birthday yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Manager</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Norman</u>				14. MOTHER'S MAIDEN NAME <u>Margaret McFadden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral tumor</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Brain activity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-18</u> , 19 <u>56</u> , to <u>6-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-19</u> , 19 <u>56</u> , and that death occurred at <u>4:25 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Bernard A. Riley</u>				ADDRESS (Street, city, town, state) <u>6-20-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 22 56</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>June 22, 56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Hopping Funeral Home Annapolis, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5790

CERTIFICATE OF DEATH

Reg. Dist. No. 05275

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			c. LENGTH OF STAY IN 1b 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS R.F.D. 1, Box 264 A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle A. Last Oktavec, Sr.				4. DATE OF DEATH Month June Day 2 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1884		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist			10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Oktavec				14. MOTHER'S MAIDEN NAME Marie Blaha			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219p32-0818		17. INFORMANT Address Wm. A. Oktavec, Jr., 3613 Lyndale Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Diabetes mellitus DUE TO (c) Diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 2 1/2 years 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 18, 1949 to June 2, 1956 ; that I last saw the deceased alive on June 2, 1956 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. M. McLaughlin M.D.				ADDRESS (Street, city or town, state) Pasadena, Md.		DATE SIGNED June 2, 1956	
PHYSICIAN'S NAME (Type) R. M. McLaughlin, M.D.				ADDRESS Pasadena, Md.		DATE SIGNED June 2, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6, 1956		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc. 2601 3 5 E. Madison St.				24a. REC'D BY REGISTRAR 4/6/56		24b. REGISTRAR'S SIGNATURE L. G. DeAlba	

BRITISH AIR

27th

1941

5791

CERTIFICATE OF DEATH

Reg. Dist. No.

73

1. PLACE OF DEATH a. COUNTY A. A. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 S. Camp Meade Rd.		d. STREET ADDRESS 200 S. Camp Meade Rd	
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Pfeiffer		4. DATE OF DEATH Month June Day 29 Year 1956	
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1874
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Amos Earp		14. MOTHER'S MAIDEN NAME Marian Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nicholas Albert Pfeiffer		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia 4x0.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral hemorrhage (multiple, small) DUE TO (c) Arteriosclerotic Heart Disease & Hypertension		INTERVAL BETWEEN ONSET AND DEATH 1 wks 5 yrs 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 1950, to June 29, 1956 , that I last saw the deceased alive on June 26, 1956 , and that death occurred at 2 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Milton Linthicum M.D.		ADDRESS (Street, city or town, state) Linthicum Heights Rd DATE SIGNED 6/29/56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 2/56	22c. NAME OF CEMETERY OR CREMATORY Western	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke		ADDRESS 4101 Edmondson Ave	
24a. REC'D BY REGISTRAR July 2, 1956		24b. REGISTRAR'S SIGNATURE Dr. Caldwell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 TOM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

5751

05777

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>30 min.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>pronounced dead at A. A. Gen. Hosp.</u>				STREET ADDRESS (If rural give location) <u>7th. Dist. Rescue Squad Amb.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Infant</u> (Middle) <u>Phipps</u> (Last)				(Month) <u>June</u> (Day) <u>13</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 13 1956</u>	9. AGE last birthday <u>30</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alton Joseph Phipps</u>				14. MOTHER'S MAIDEN NAME <u>Etta Jeanette Marshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>Alton J. Phipps, Deale Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
M. <u>6/20/1956</u>							
22. I hereby certify that I attended the deceased from <u>Deale, Md.</u> , on <u>June 13, 1956</u> , that I last saw the deceased alive on <u>June 13, 1956</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>June 19 1956</u>			
ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/20/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. James</u>		LOCATION (City, town, or county) (State) <u>Maryland</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
DATE <u>6/20/1956</u>							



CERTIFICATE OF DEATH

Reg. Dist. No. 21

5752

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton - Pasadena R.F.D.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.</u>		d. STREET ADDRESS <u>Gov. Ritchie Hwy.</u>	
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>C.</u> Last <u>Pocock</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-10, 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Casualty</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Pocock</u>		14. MOTHER'S MAIDEN NAME <u>Annie Vaelker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>2-15-07-2162</u>	
17. INFORMANT <u>Mrs. Esther Pocock</u>		Address <u>Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Two-to-one heart block</u> DUE TO (c) <u>Interventricular Cardiac Vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. [City or town] [County] [State]	
21. I certify that I attended the deceased from <u>February 13, 1956</u> to <u>June 14, 1956</u> that I last saw the deceased alive on <u>June 14, 1956</u> and that death occurred at <u>9:28 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans, M.D.</u>		DATE SIGNED <u>June 6/15/56</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>June 18, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>	22d. LOCATION (City, town, or county) [State] <u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. French</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>Dr. Wm. J. French</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. J. French</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5792

CERTIFICATE OF DEATH

05779

Reg. Dist. No. 24

1 PLACE OF DEATH a. COUNTY <u>St. Anne</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>St. Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL (and give nearest town) <u>Jones Station</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL (and give nearest town) <u>Jones Station</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Powell</u> Middle <u>John</u> Last		4. DATE OF DEATH <u>June</u> Month <u>1</u> Day <u>1956</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colore</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25, 1884</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Petersburg Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard E. Powell</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Orsiah Powell Jones Station</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Congestive Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-4-55</u> , 19____, to <u>6-1-56</u> , 19____, that I last saw the deceased alive on <u>5-26-56</u> , 19____, and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 Cathedral St</u> DATE SIGNED <u>6-2-56</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		<u>62 CATHEDRAL ST</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-3-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Earle Heights</u>	22d. LOCATION (City, town, or county) (State) <u>Jones Station, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Johnson--34 Lafayette Ave. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>6-5-56</u> 24b. REGISTRAR'S SIGNATURE <u>Wm. J. Kucika</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2. 1. 1970

10. 1. 1970

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22, Fil 149 6-27-56 et

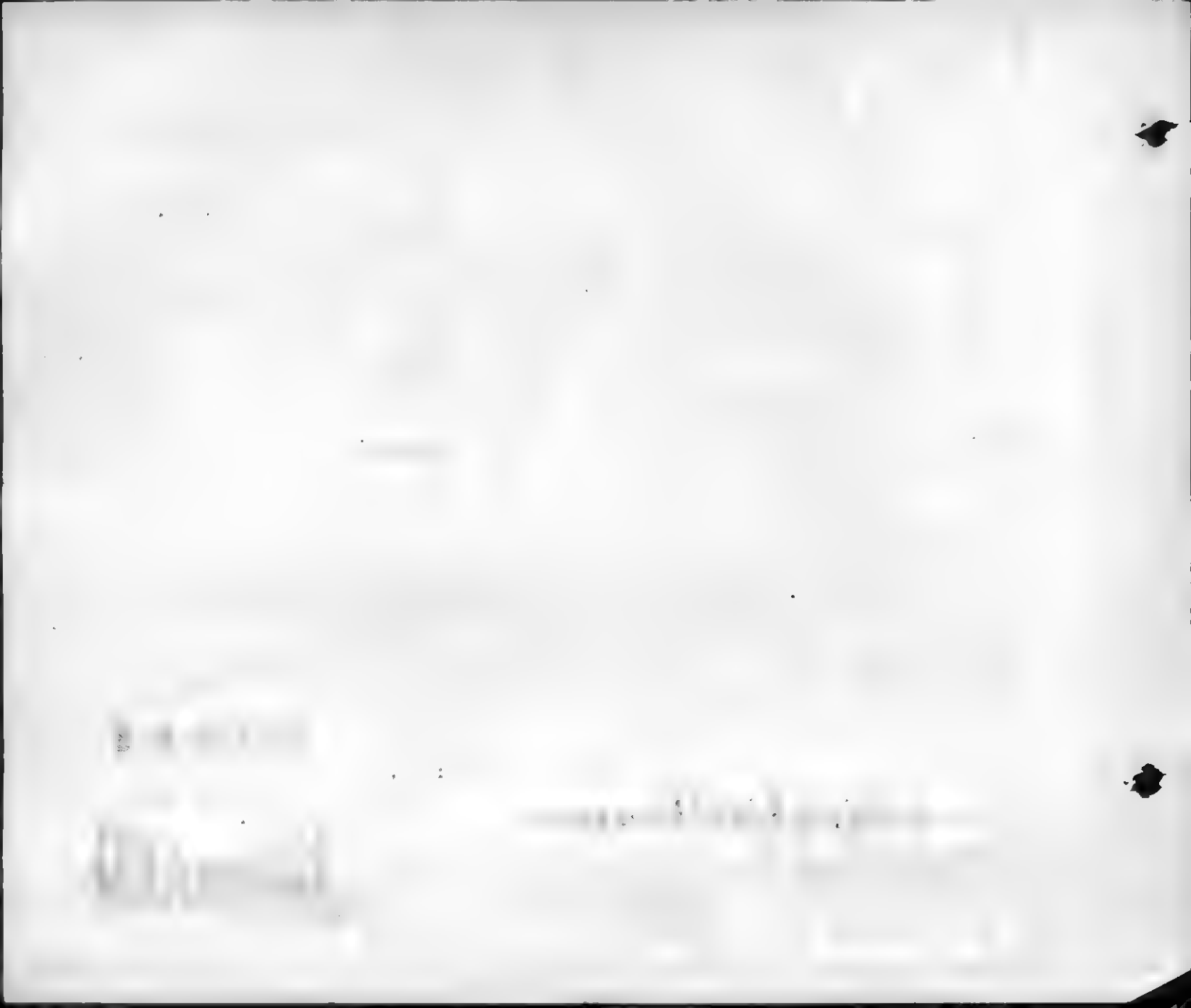
5793

CERTIFICATE OF DEATH

05780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 23 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Box 271, Silver Spring, Rte. #2		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alfred Middle Harrison Last Pumphrey				4. DATE OF DEATH Month 6 Day 13 Year 19 56			
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/89	9. AGE (In years lost birthday) 67 yrs	IF UNDER 1 YEAR Months - Days - Hours - Min -	IF UNDER 24 HRS Hours - Min -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WWI		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decubital ulcers DUE TO (c) Cerebral Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 months 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - - - -			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/5 19 55 , to 6/13 19 56 , that I last saw the deceased alive on 6/13 19 56 , and that death occurred at 7:45 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/14/56 ACTUAL SIGNATURE Hildegard Heard Reissmann M.D. PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann Arlington, Nat. Arlington, Va.							
22a. BURIAL, CREMATION, or other disposal (Specify) Interment		22b. DATE OF BURIAL 6/18/56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l		22d. LOCATION (State or foreign country) VA	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Smullen Rux Hall				24a. REC'D BY REGISTRAR ONE		24b. REGISTRAR'S SIGNATURE Matthias M. Joyce	



5794

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsmere Shores</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsmere Shores</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Groth Drive</u>		d. STREET ADDRESS <u>Groth Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Clifton Edward Rawlings</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 12, 1916</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charlter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clifton E. Rawlings, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Melvina D. Rawlings</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound - Head</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Suicide - 22 Cal. Rfle -</u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Hillsmere</u> (County) <u>Anne Arundel</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. L. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6/10/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-13-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>	22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>6-11-56</u>		DATE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please re-execute the certificate within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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100

5753

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hospt.</u>				d. STREET ADDRESS <u>16 German St.</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>E.</u> Last <u>REYNOLDS</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1900</u>	9. AGE (In years last birthday) <u>55</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) <u>Electrician U.S. & P. Station</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>	11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Irene M. Reynolds</u> #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ac. Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO (c) <u>Severe Diabetes Mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>yes.</u> <u>yes.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>49</u> , to <u>June 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 6</u> , 19 <u>56</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.				ADDRESS (Street, city or town, state) <u>Annapolis Md 6/7/56</u>			
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS,</u>				DATE SIGNED <u>Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Edwards Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Parole Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor and Sons</u>				ADDRESS <u>Annapolis, Md</u>		24a. REC'D BY REGISTRAR DATE <u>6/8/1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director or TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. ARMY

OFFICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05783

Reg. Dist. No. 22

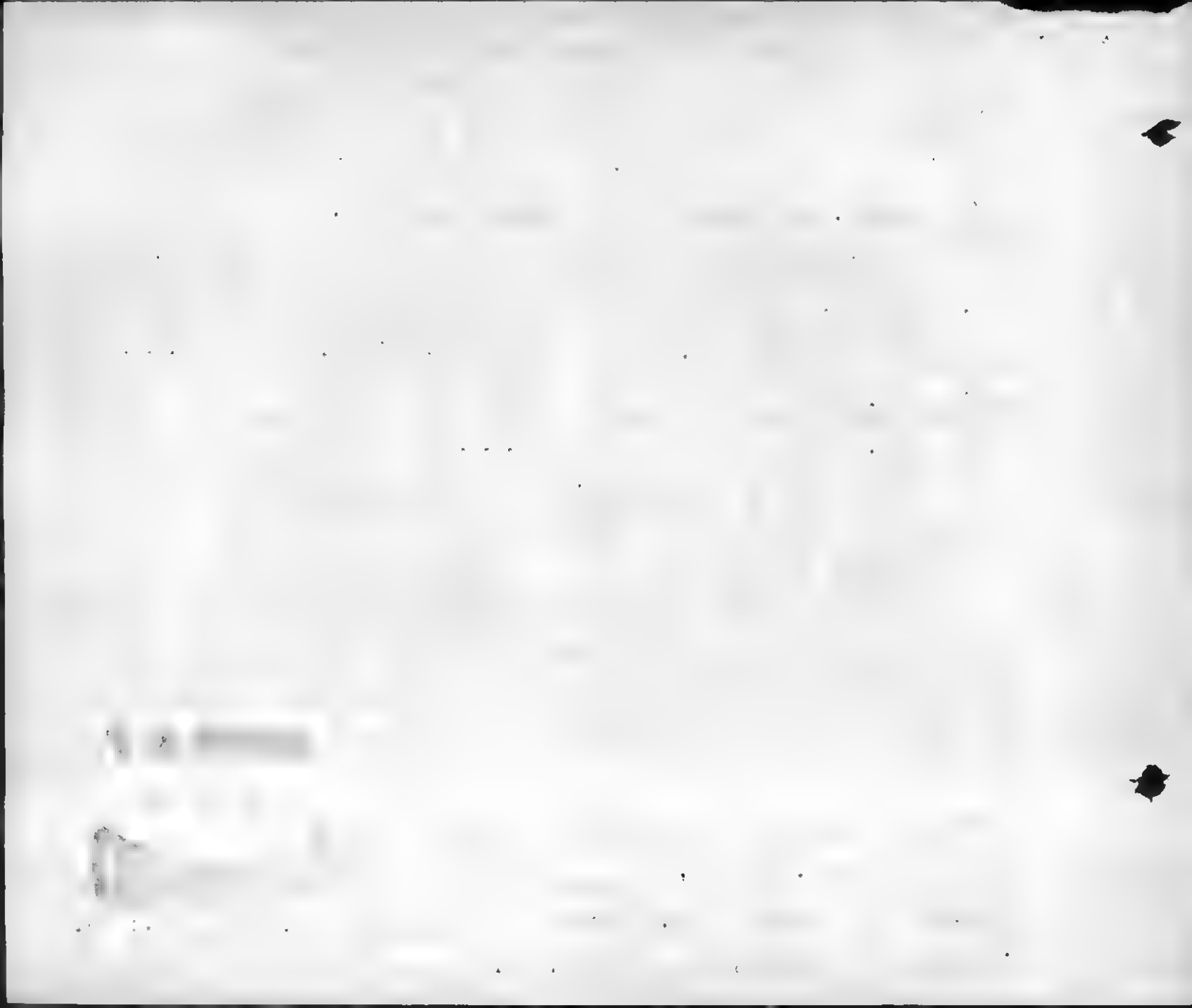
5795

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u> c. LENGTH OF STAY IN lb <u>77 day.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Private home in an automobile</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) STATE <u>MD</u> COUNTY <u>Pr</u> e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Pleasant</u> d. STREET ADDRESS <u>220 Steven Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Allen Robb</u> First Middle Last			4. DATE OF DEATH Month Day Year <u>June 9th. 1956</u> <u>19</u>				
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/13/81</u>	9. AGE (in years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Government Clerk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kennedy, Illinois.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			
13. FATHER'S NAME <u>William T. Robb</u>			14. MOTHER'S MAIDEN NAME <u>Welthy Lowry</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. J.A. Robb (Wife)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Hopping</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Gustave H. Hopping M.D.</u>			DATE SIGNED <u>June 10/56</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Kirkley</u>		24a. REC'D BY REGISTRAR <u>June 13 56</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Neelup</u>			
ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the cause of the delay. The word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detailed for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5796 CERTIFICATE OF DEATH

05784

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort George G. Meade</u>		<u>10 Months</u>		TOWN <u>Carden</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (if rural give location) <u>33 S. Main Street</u>			
3. NAME OF <u>MURRAY</u> (First) (Middle) (Last) <u>SAPOFF</u>				4. DATE OF DEATH <u>27 June</u> 19 <u>56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>15 October 1912</u>	
9. AGE last birthday <u>43</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>Latvia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>11 years 7 months</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT & ADDRESS <u>Army Service Records</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary artery occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 Hours</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>27 June</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>27 June</u> , 19 <u>56</u> , to <u>27 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>27 June</u> , 19 <u>56</u> , and that death occurred at <u>8:25 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Michael A. Dobridge</u>				ADDRESS (Street, city, town, state) <u>1201 Bushey Drive, Wheaton, Md.</u>			
DATE <u>27 June 56</u>				DATE SIGNED <u>27 June 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Unk</u>		NAME OF CEMETERY OR CREMATORY <u>Unk</u>		LOCATION (City, town, or county) (State) <u>New York</u>	
24. REC'D BY REGISTRAR <u>W.L. SAYLOR, 1ST LT, MSC</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook Inc.</u> ADDRESS <u>Balto, Md</u>			

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5797

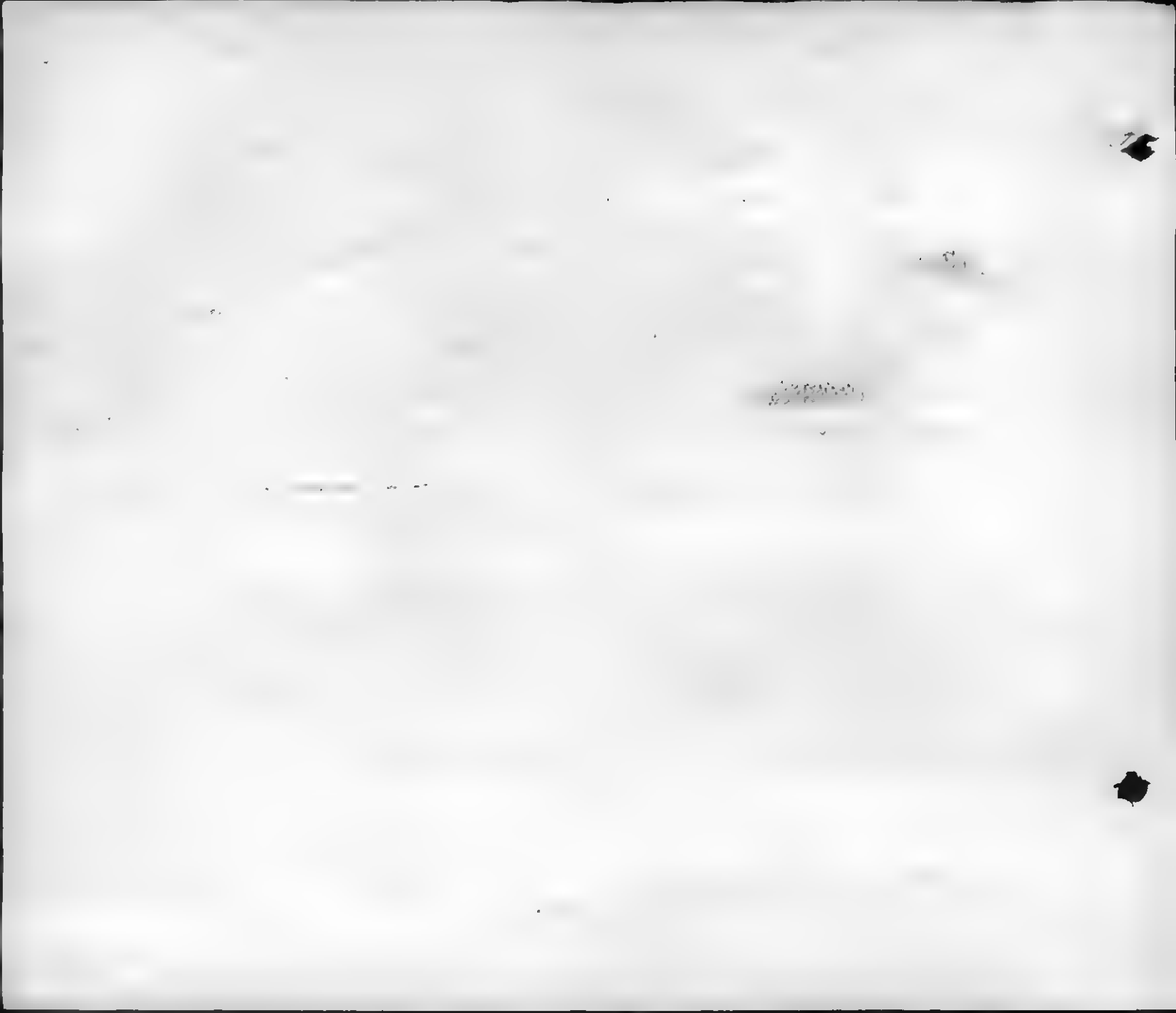
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundle</u>	MARYLAND	STATE <u>Ma</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Patasko Park</u>	LENGTH OF STAY (in this place) <u>35 Yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Patasko Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>219 Bolivar Ave</u>		STREET ADDRESS (If rural give location) <u>219 Bolivar Ave</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) <u>Bertie Scott</u>		DATE OF DEATH: <u>6</u> <u>30</u> <u>1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>6-2-00</u>
9. AGE last birthday: <u>49</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William Scott</u>		14. MOTHER'S MAIDEN NAME: <u>Josephine McConider</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Alice Reynolds</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Septic Infection</u>			
ANTECEDENT CAUSE (B) <u>Septicemia</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Leg ulcers</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 18 1956</u> to <u>June 30 1956</u> , that I last saw the deceased alive on <u>June 18 1956</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>2-3-56</u>	
NAME OF CEMETERY OR CREMATORY: <u>Carver Memorial</u>		LOCATION (City, town, or county) (State): <u>Howard County</u>	
24. FUNERAL DIRECTOR: <u>Elmer J. Wilson</u>		ADDRESS: <u>Box 212 Elmer</u>	
25. REGISTRY BY LOCAL REGISTRAR: <u>6/3/56</u>		REGISTRAR'S SIGNATURE: <u>G. W. Hedrich</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



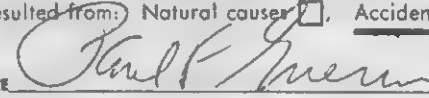


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05786

Reg. Dist. No. 25

5798

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Little Grove Rd.				d. STREET ADDRESS 658 Creswell Road Hammonds Lane -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First August Middle R. Last Seifert				4. DATE OF DEATH Month 6 Day 1 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1908	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coast Guard Capt.	
10b. KIND OF BUSINESS OR INDUSTRY U. S. Coast Gd.		11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME John J. Seifert				14. MOTHER'S MAIDEN NAME Sophia Rubezch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Josephine Kosmicki Seifert Home			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto					
20c. TIME OF INJURY Month, Day, Year Hour 10:45 a. m. 6 1 56		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) N. Anne Arundel Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural cause <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/1/56	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				22a. BURIAL, CREMATION, REMOVAL (Specify) Buried			
22b. DATE THEREOF June 5, 1956		22c. NAME OF CEMETERY OR CREMATORY Long Cross		22d. LOCATION (City, town, or county) Anne Arundel Co. Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE 				ADDRESS 4401 Ritchie Highway		24a. REC'D BY REGISTRAR DATE 6-11-56	
24b. REGISTRAR'S SIGNATURE 				24c. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used for burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

A34

22.10.1941

1. 1. 1942

1. 1. 1942

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 4, F 17-4799 6-25-56 et

05787

5799 **CERTIFICATE OF DEATH**Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eastport</u>		LENGTH OF STAY (in this place) <u>46 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eastport</u>			
TOWN				STREET ADDRESS (If rural give location) <u>417 Third St</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>417 Third St</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u> (Middle) <u>A.</u> (Last) <u>SMITH</u>				June 14, 1956			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 27, 1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Academy</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Wm H. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Julia A. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes 1905-1907</u>		16. SOCIAL SECURITY NO. <u>219-32-3067</u>		17. INFORMANT & ADDRESS <u>Caroline M. Smith</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic cardiovascular disease.</u>						<u>15 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 19 55</u> , to <u>June 14 19 56</u> , that I last saw the deceased alive on <u>June 12 19 56</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>B. B. Smith</u>				ADDRESS (Street, city, town, state) <u>M.D. Amos Garrett Blvd. Annapolis, Md.</u>			
				DATE SIGNED <u>6/18/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6/18/56</u>		NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
24. REC'D BY REGISTRAR <u>6/18/1956</u>		REGISTRAR'S SIGNATURE <u>J. J. O'Connell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard H. D. Luty</u>		ADDRESS <u>Galesville Md.</u>	



5800
CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Pennsylvania</u> COUNTY <u>Lebanon</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort G. G. Meade</u>		LENGTH OF STAY (in this place) <u>4 Months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lebanon</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>231 South 10th Street</u>			
3. NAME OF DECEASED (Type or Print) <u>STEPHEN MICHAEL SNYDER</u>				4. DATE OF DEATH <u>June 27 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>18 November 55</u>	
9. AGE last birthday yrs. <u>7</u>		10. IF UNDER 1 YEAR Months <u>9</u>		11. IF UNDER 24 HRS. Days <u>9</u>		12. IF UNDER 24 HRS. Hours <u>9</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James R. Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Clara L Nepi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mother, 207 Glen Road Glen Burnie, Maryland</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>Consecutive Heart Failure</u>						<u>3 days</u>	
2. ANTECEDENT CAUSE(S) DUE TO <u>Congenital Heart Disease</u>						<u>7 Mon 9 Days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Congenital Heart Disease</u>							
C							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15 May 1956</u> to <u>27 June 1956</u> that I last saw the deceased alive on <u>27 June 1956</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
HERBERT L. NEEDLEMAN, CAPT, MC.				ADDRESS (Street, city, town, state) <u>USAH, Fort G.G. Meade, Md. 27 June 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Unknown</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lebanon, Pennsylvania</u>	
24. REC'D BY REGISTRAR <u>W.L. Saylor, 1st Lt, MSC</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thompsons Funeral Home, Lebanon, Pa.</u>			
DATE <u>27 Jun 56</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



5801

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY Anne Arundel Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carvel		d. STREET ADDRESS Carvel Rd.	
3. NAME OF DECEASED (Type or print) First Norman Middle Stadiger Last Stadiger		4. DATE OF DEATH Month 6 Day 12 Year 56	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/84
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realter		10b. KIND OF BUSINESS OR INDUSTRY Self - Emp.	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family - Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung. 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiac Vascular Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1956 to June 12 1956 , that I last saw the deceased alive on June 11, 1956 , and that death occurred at 10:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Brady Smith M.D.		DATE SIGNED 6/13/56	
PHYSICIAN'S NAME (Type) J. BRADY SMITH		RIVIERA BEACH MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) B	22b. DATE THEREOF 6/15/56	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes		24a. REC'D BY REGISTRAR DATE 6-18-56	
		24b. REGISTRAR'S SIGNATURE Louis J. De Alba	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5802

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

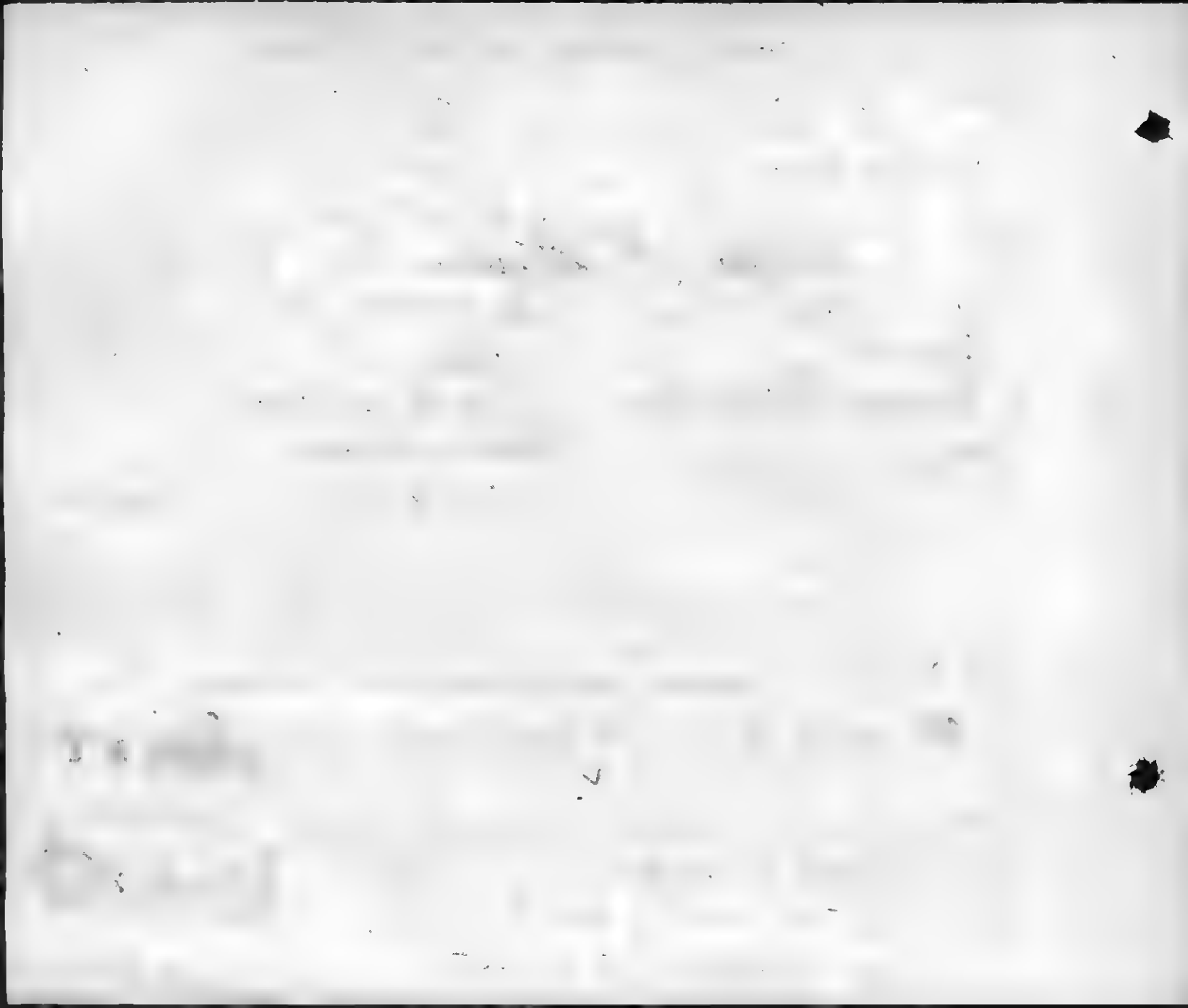
05790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severn River</i>		c. LENGTH OF STAY IN 1b <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>2021 Fleet</i>	
3. NAME OF DECEASED (Type or print) <i>Ralph F. Stapleton</i>		4. DATE OF DEATH Month <i>6</i> Day <i>24</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 30 - 1932</i>
9. AGE (In years last birthday) <i>23</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lewis Stapleton</i>		14. MOTHER'S MAIDEN NAME <i>Edith Snook</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Betty Staples</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>DROWNING</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Sudden</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Thrown out of boat while making turn</i>	
20c. TIME OF INJURY Month, Day, Year <i>AM 6-24 1956</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) <i>Severn River</i>		20f. (City or town) (County) (State) <i>AA Co MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Elmer Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>ELMER LINHARDT</i>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6-26-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Newbury Baptist</i>		22d. LOCATION (City, town, or county) (State) <i>CASSVILLE PA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook Inc</i>		24. REGISTRAR'S SIGNATURE <i>Clara Staples</i>	
ADDRESS <i>1217 ST. PAUL ST</i>		DATE <i>6-24-56</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



CERTIFICATE OF DEATH

5893

MEDICAL CERTIFICATION

VS A15 (4)
9/55

100-100

100-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

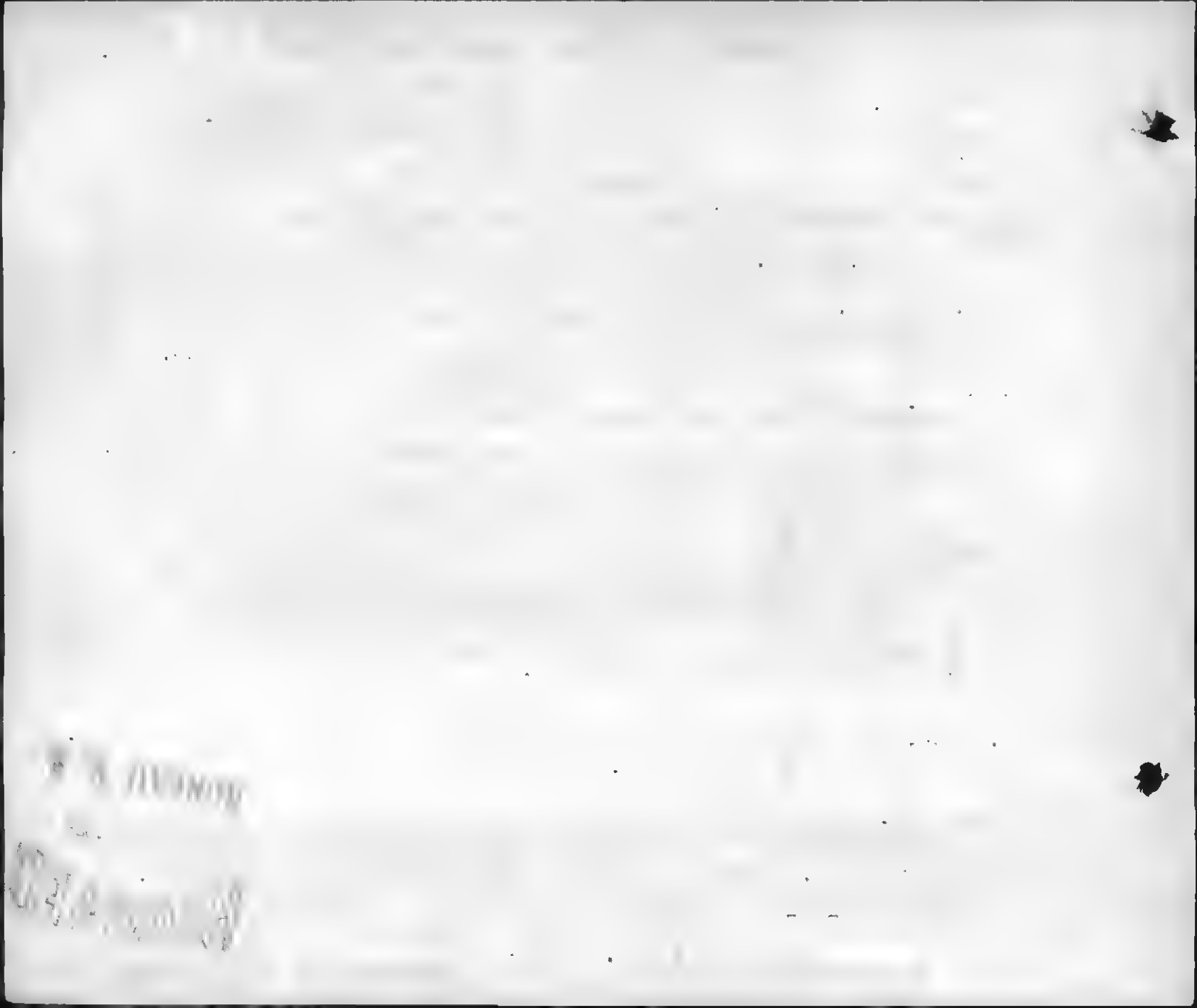
05792
24

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pacodons</u> c. LENGTH OF STAY IN 1b <u>1 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magothy River, Beechwood Park</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Patuxent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>24 Jones Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Stewart</u> 4. DATE OF DEATH Month <u>June</u> Day <u>24th</u> Year <u>1956</u>				5. SEX <u>M.</u> 6. COLOR OR RACE <u>C.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6/28/33</u> 9. AGE (In years last birthday) <u>22 yrs.</u> IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William H. Stewart</u> 14. MOTHER'S MAIDEN NAME <u>Genivia Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT Address <u>Mrs. G. Stewart, (Mother) 24 Jones Avenue, Balt. Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>929.8</u> IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped off a row boat.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour <u>5:55 P.M.</u> <u>6/24/56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Magothy River</u>		20f. (City or town) <u>Beechwood Beach</u> (County) <u>A.A.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural cause <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> EXAMINER'S NAME (Type) <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>6/25/56</u> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Glen Burnie, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-27-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Star Cem</u>		22d. LOCATION (City, town, or county) <u>Catonsville</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Frances A. Hensley</u> ADDRESS <u>578 W. Middle St</u>				24a. REC'D BY REGISTRAR <u>June 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. D. Allen</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" should be written in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

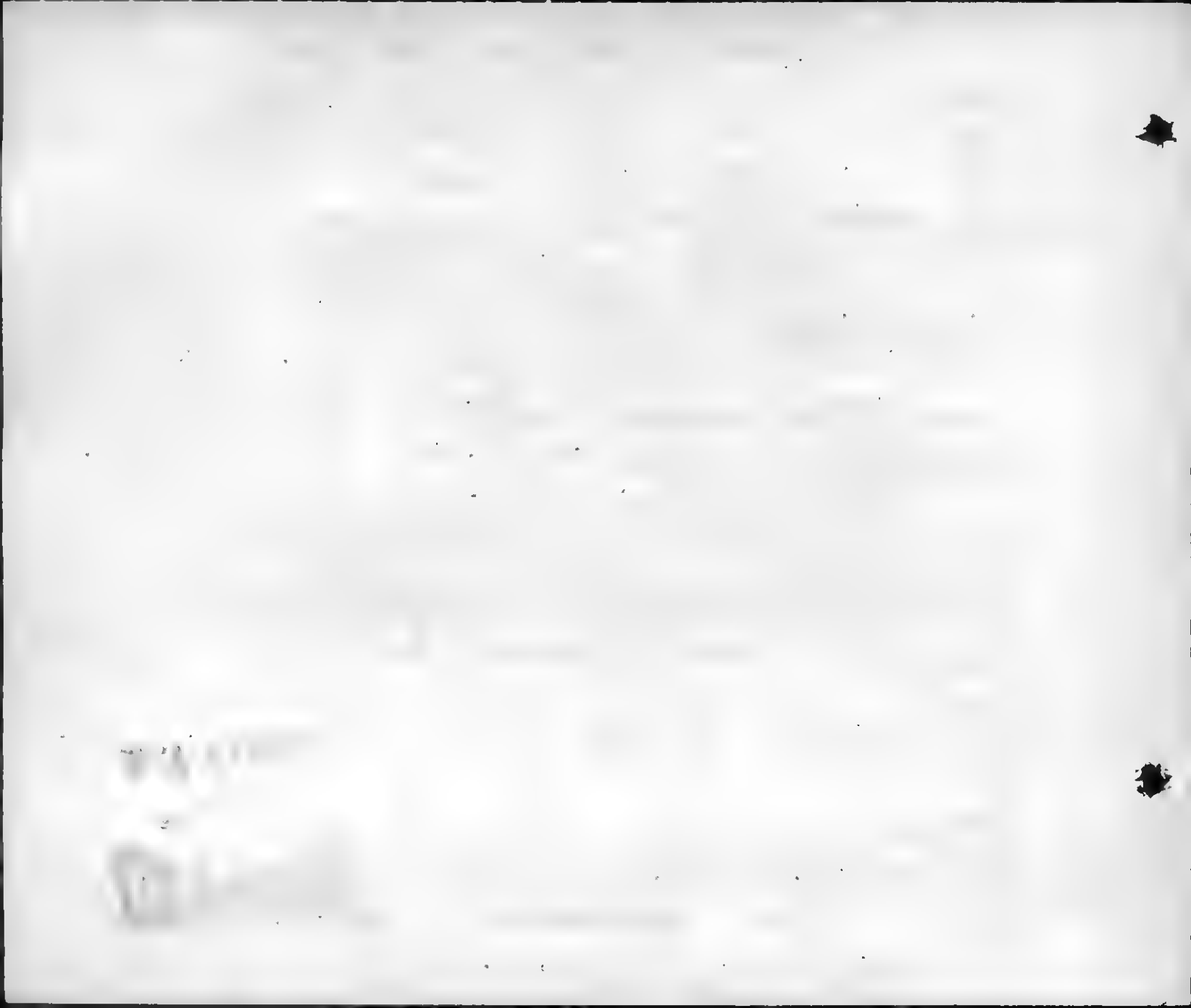
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05793

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>Anne rundel</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Virginia</u> <u>D</u> COUNTY <u>Russell</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crystal Beach, P.O. Pasadena</u>			c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magothy River</u>			d. STREET ADDRESS <u>Coolwood</u>		
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Stinson</u> Last <u>Stinson</u>			4. DATE OF DEATH Month <u>June</u> Day <u>14th</u> Year <u>19 56</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/19/21</u>	9. AGE (In years last birthday) <u>34</u> yrs.	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>14</u> Mln. <u>14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attending School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cleveland Virginia.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Glen Davis Stinson</u>			14. MOTHER'S MAIDEN NAME <u>Florence Agnes Arttrip</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Herbert E. Stinson, (Uncle) Baltimore 27 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (a), stating the underlying cause lost. DUE TO (c) <u>Sudden</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Drowning</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowning</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> a. m. <u>6/14/56</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Magothy River</u>	
		20f. (City or town) <u>Crystal Beach, A.A. Maryland.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/14/56</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Glen Burnie, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>	
		22d. LOCATION (City, town, or county) <u>Honaker, Virginia</u>		(State)	
23. FUNERAL DIRECTOR'S NAME <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>6-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Louis J. DeAlba</u>	



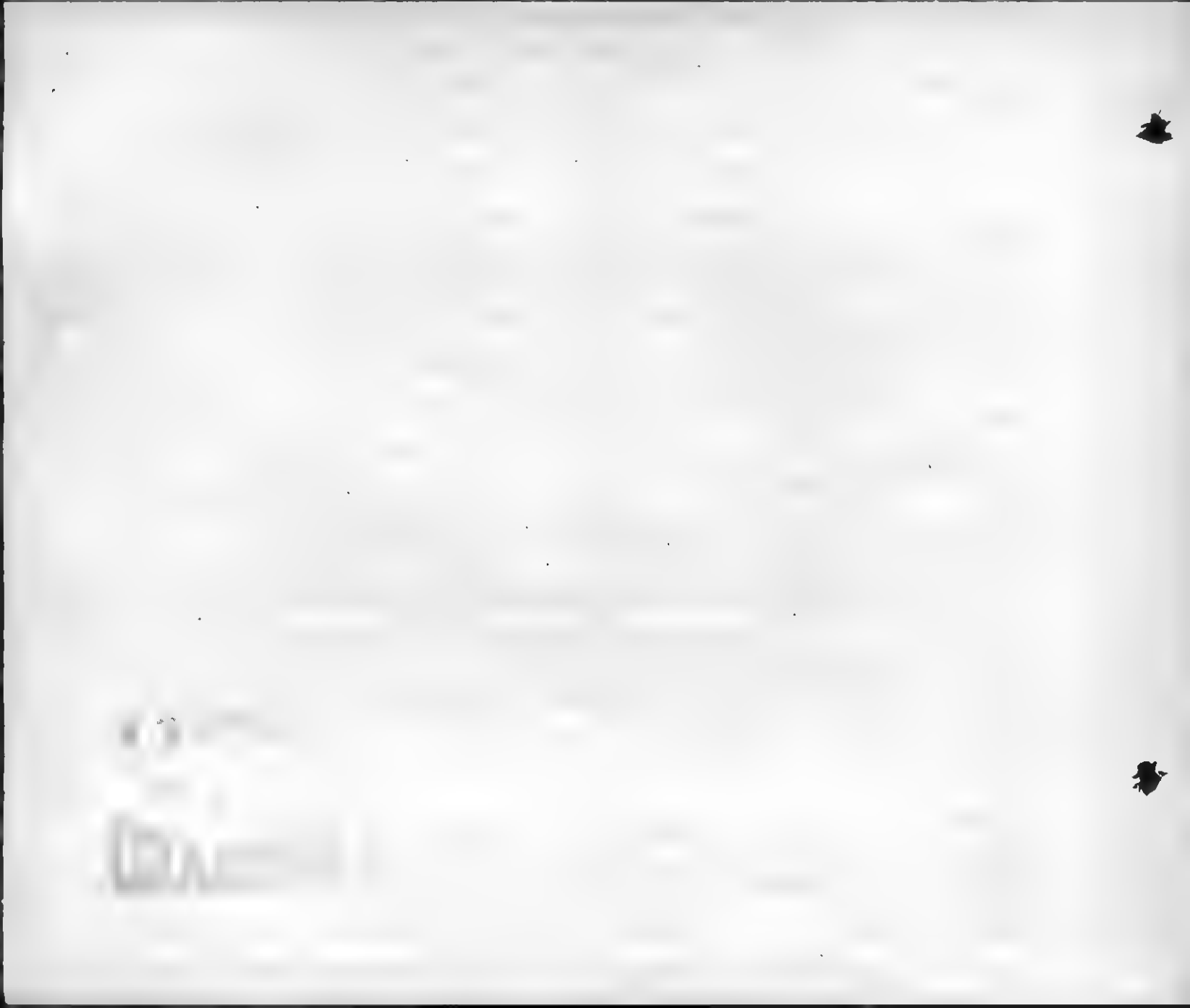
Reg. Dist. No. 24

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <i>La Co</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>GA Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Russell Lake Shore</i>		c. LENGTH OF STAY IN 1b <i>35 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Blond Park GA Co MD</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Blond Park</i>		d. STREET ADDRESS <i>Pasadena MD</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Amelia I Strecker</i>		4. DATE OF DEATH Month <i>June</i> Day <i>13</i> Year <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 24 - 1894</i>	9. AGE (In years last birthday) <i>62 yrs</i>	IF UNDER 1 YEAR: Months <i>6</i> Days <i>13</i> Hours <i>13</i> Min. <i>13</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>---</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Richard Kohloff</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Charles Strecker</i> Address <i>Blond Park GA Co MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i> <i>4341</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Congestive heart failure</i> DUE TO (c) <i>Hypertension, mild</i> INTERVAL BETWEEN ONSET AND DEATH <i>1-hour</i> <i>6-years</i> <i>Not known</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>diabetes mellitus - 5 years duration</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <i>a. m.</i> <i>19</i> Month <i>May</i> Day <i>1</i> Year <i>1954</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>May 1</i> , 19 <i>54</i> , to <i>June 13</i> , 19 <i>56</i> ; that I last saw the deceased alive on <i>June 13</i> , 19 <i>56</i> , and that death occurred at <i>11:15 P.M.</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>		M.D. <i>R.F.D.S. Box 442 Pasadena MD</i>		DATE SIGNED <i>6/13/56</i>	
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>		ADDRESS <i>R.F.D.S. Box 442 Pasadena MD</i>		DATE <i>6/13/56</i>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 16-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Green Haven Cemetery, Gaithersburg GA Co MD</i>	
22d. LOCATION (City, town, or county)		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard A. Fink</i>		ADDRESS <i>426 Brambling Rd</i>		24a. RECEIVED BY REGISTRAR <i>L. J. Dealba</i>	
24b. REGISTRAR'S SIGNATURE		24c. DATE		24d. TIME	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8 Filed 1986-12-56 et

05795

5897 **CERTIFICATE OF DEATH**

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glen Burnie</u>		LENGTH OF STAY (in this place) <u>2 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>207 Lincoln Ave.</u>				STREET ADDRESS (If rural give location) <u>1706 N. Calvert St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Warren Octavius Towles</u>				4. DATE OF DEATH (Month) <u>6/10/56</u> (Day) <u>19</u> (Year)			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>4/13/56</u> <u>4/13/73</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Leicester, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas P. Towles</u>				14. MOTHER'S MAIDEN NAME <u>Elberta Iceland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Mabel T. Kirkham (daughter)</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Uremia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Nephritis</u>						<u>3 Month</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>General Arteriosclerosis</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>6/6/56</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/8/56</u> , 19 <u>56</u> , to <u>6/10/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/8/56</u> , 19 <u>56</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Justin X Pace</u>				DATE SIGNED <u>6/10/56</u>			
M.D. <u>Glen Burnie, M.D.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6/12/56</u>		NAME OF CEMETERY OR CREMATORY <u>WHITE MARSH CH. CEM.</u>		LOCATION (City, town, or county) (State) <u>BROOKLINE, VA.</u>	
24. REC'D BY REGISTRAR <u>6-13-56</u>		REGISTRAR'S SIGNATURE <u>Louis J. De Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Sorce</u>		ADDRESS <u>4001 Ritchie Hwy</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

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Reg. Dist. No. 023

VS. A15ME(5)
SM 9/55

1/3 1/2

1/3 1/2

1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

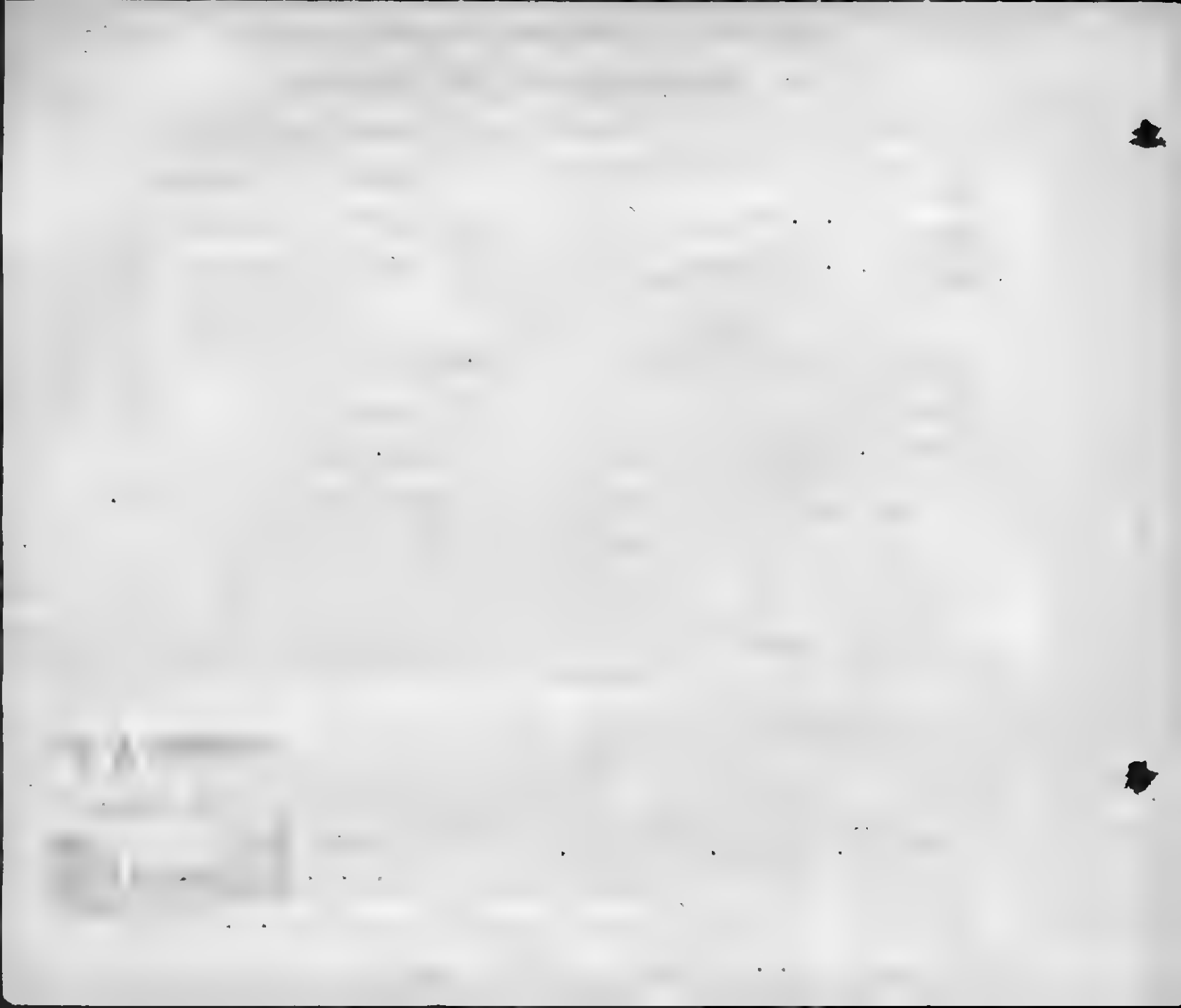
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05797

5809 **CERTIFICATE OF DEATH**

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>_____</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Fort G. G. Meade</u>		LENGTH OF STAY (in this place) <u>16 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>5939 Hilltop Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>INFANT GIRL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 17 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>June 17, 1956</u>	
9. AGE last birthday Yrs. <u>3</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		11. IF UNDER 24 HRS. Hours <u>3</u> Min. <u>40</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel E. Walker</u>				14. MOTHER'S MAIDEN NAME <u>Evva T. Bywater</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Evva Walker, Mother, 5939 Hilltop Avenue, Balto, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs 40 min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>_____</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>17 June</u>, 19<u>56</u>, to <u>17 June</u>, 19<u>56</u>, that I last saw the deceased alive on <u>17 June</u>, 19<u>56</u>, and that death occurred at <u>0415AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>C. Richard G. Gilbert</u>				ADDRESS (Street, city, town, state) <u>USA, Ft. G. G. Meade, Md.</u>		DATE SIGNED <u>17 Jun 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>19 Jun 56</u>		NAME OF CEMETERY OR CREMATORY <u>Removed to Medical Lab</u>		LOCATION (City, town, or county) (State) <u>Fort G. G. Meade, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>None</u>		ADDRESS	
DATE <u>18 Jun 56</u>		REGISTRAR'S NAME <u>W. L. GAYLOR, ACT. LT. JSC</u>		DATE <u>None</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05798

Reg. Dist. No.

13

5810

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u> d. STREET ADDRESS <u>Broadview Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>PEARL</u> Last <u>WARFIELD</u>			4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1876</u>	9. AGE (In years last birthday) <u>79 yrs.</u>	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
13. FATHER'S NAME <u>(unknown) Kelley</u>			14. MOTHER'S MAIDEN NAME <u>(unknown)</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mr. Paul R. Warfield Broadview Blvd. Linthicum</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arterio Sclerosis</u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> NAME (Type) <u>Gustave H. Faubert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 28 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Ling</u> ADDRESS <u>Glen Burnie, Md.</u>			24a. REC'D BY REGISTRAR DATE <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Caldwell Woodruff</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Medical Examiner's Office along with form PM-3. Page 3 may be retained for your files. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CHURCH A

1000 1000 1000

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05799

5811 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Burnie</u>		LENGTH OF STAY (in this place) <u>2 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1309 William St.</u>				STREET ADDRESS (If rural give location) <u>1309 William St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Harry Wehner Sr.</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>24</u> (Year) <u>1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>12/12/80</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Presshand</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wehner</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-77-7657</u>		17. INFORMANT & ADDRESS <u>Harry Wehner Jr. (Son).</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Hypertensive Cardio-Vascular Diseases</u>						INTERVAL BETWEEN ONSET AND DEATH <u>over 3 months.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 10th, 1956</u> to <u>6/21/56</u> , 19....., that I last saw the deceased alive on <u>5/20/56</u> , 19....., and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Kustine H. Paecher M.D.</u>		DATE THEREOF <u>June 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard G. Fink</u>		ADDRESS <u>Glen Burnie Md</u>	

BURMAN A. J.

1 56

RECEIVED

5812 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Millersville</u>		<u>3 Wks.</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home</u>				STREET ADDRESS (If rural give location) <u>3507 Walbrook Ave.,</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>E.</u> (Last) <u>Whaley</u>				(Month) <u>June</u> (Day) <u>19,</u> (Year) <u>19 56.</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Sept. 27, 1868</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>---</u>		<u>Md.</u>			
13. FATHER'S NAME <u>Bernard Saidler</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Warren</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Gladys V. Whaley, Pasadena 2, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Acute pulmonary edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive heart failure</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized arteriosclerosis</u>				<u>with known</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>bilateral blindness</u>				<u>3 years.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 16, 1956</u> to <u>June 19, 1956</u> , that I last saw the deceased alive on <u>June 19, 1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>K. M. McLaughlin</u>		M.D. <u>Pasadena, Md.</u>		DATE SIGNED <u>June 19, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-22-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Katharine M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>G. Howard Strong 3207 W. North Ave.</u>			
DATE <u>6 21 56</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



VS A15 (4)
ISM 9/55

THE UNIVERSITY OF CHICAGO

9

11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5755

CERTIFICATE OF DEATH

058021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Inne Wundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Statenburg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Statenburg</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Statenburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Statenburg General Hosp.</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Pennis</u> Middle <u>Wilson</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-5-1893</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Serv.</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Wilson</u>	
14. MOTHER'S MAIDEN NAME <u>Henrietta Wilson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Emma Wilson - Statenburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arterio-sclerotic Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular disease</u> DUE TO (c) <u>Cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/24/56</u> to <u>6/27/56</u> , that I last saw the deceased alive on <u>6/24/56</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u>		DATE SIGNED <u>110-CLAY ST ANNAPOLIS, Md</u>	
PHYSICIAN'S NAME (Type) <u>R. L. RICHARDSON</u>		ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-30-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	22d. LOCATION (City, town, or county) (State) <u>Statenburg, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Annapolis, Md</u>		24a. REC'D BY REGISTRAR <u>Wm. J. French</u>	
ADDRESS <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05803

CERTIFICATE OF DEATH

5756

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUND</u>		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUND</u>		STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place) <u>6-MONTHS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		TOWN <u>Glen Burnie</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home wood-Conalescant Home</u>				STREET ADDRESS (If rural give location) <u>1002 Nancy Road-Dak Ridge</u>			
3. NAME OF DECEASED (Type or Print) <u>Lila Elizabeth - Woodbury</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 4, 1885</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi Wingo</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mr. Mark Woodbury 1002 Nancy Road Glen Burnie, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>CEREBRAL VASCULAR ACCIDENT</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBRAL ARTERIOSCLEROSIS</u>				<u>unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>DEC 5</u> , 19 <u>50</u> , to <u>17 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>17 June</u> , 19 <u>56</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward Beck</u> M.D. <u>4 South St. Annapolis</u>				DATE SIGNED <u>6/17/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 20/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. REC'D BY REGISTRAR <u>6-21-56</u>		REGISTRAR'S SIGNATURE <u>Dr. Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. French</u>		ADDRESS <u>Glen Burnie, Md.</u>	

CERTIFICATE OF DEATH

7758

NOTIFICATION

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Manner of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]

BUREAU V. 3

JUN 21 1956

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5813

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05804

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Pasadena</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Marley Creek, off Johnson Peer.</u>				d. STREET ADDRESS <u>Mountain Road.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Melvin Martin Wright</u>				4. DATE OF DEATH Month Day Year <u>June the 13th. 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/23/39</u>	9. AGE (In years last birthday) <u>16</u> yrs.	IF UNDER 1 YEAR Months Days <u>16</u>	IF UNDER 24 HRS. Hours Min. <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attending School</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>University Hosp. Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milton James Wright</u>				14. MOTHER'S MAIDEN NAME <u>Esthel Stephney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Milton James Wright (Father)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Browning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>929.8</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned in Marley Creek, A.A. County.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>1.50 6/13/56 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Marley Creek</u>		20f. (City or town) (County) (State) <u>Glen Burnie, A.A. Maryland.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 13th. 1956.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Handstown A.A. Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>				ADDRESS <u>802 Madison Ave.</u>		24a. REC'D BY REGISTRAR <u>June 19 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Louis J. DeAlba</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

NEW YORK STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

NOV 19 1956

RECEIVED